Managing the Needs of Drunk and Incapable People in Scotland: a Literature Review and Needs Assessment
MANAGING THE NEEDS OF DRUNK AND INCAPABLE PEOPLE IN SCOTLAND:

A LITERATURE REVIEW AND NEEDS ASSESSMENT

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The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.
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- Gordon Samson, Central Scotland Police (ACPOS representative)
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A NOTE ABOUT TERMINOLOGY

So-called “designated places” were introduced in Scotland under section 5 of the Criminal Justice (Scotland) Act 1980. The legal definition of the term is “a place designated by the Secretary of State … as a place suitable for the care of drunken persons”. (Criminal Justice (Scotland) Act 1980, Part I, Section 5, para 1.)

Because the term “designated place” has a legal definition in Scotland, the term “sobering-up service” will be used in preference to the term “designated place” to refer to services in Australia and North America that provide a place of care for intoxicated individuals.

The term “places of safety” will be used throughout this report to refer more broadly to a wide range of interventions which have developed in Scotland and elsewhere to address the immediate care needs of people found drunk in public.
EXECUTIVE SUMMARY

Chapter 1 – Introduction

1. This is the final report of a research study commissioned by the Scottish Government and conducted by Griesbach & Associates between June and November 2008. The purpose of this research was to carry out a needs assessment, to identify what need there is in Scotland for services for people who become drunk and incapable in public. This involved not only estimating the size and nature of the problem, but also looking in detail at how the needs of this population are currently being addressed, both in Scotland and elsewhere, and how those needs may be addressed most effectively.

2. The term “drunk and incapable” is used to refer to persons who are intoxicated to such a level that it is impossible for them to look after themselves. Thus, these individuals are vulnerable and at risk of harm to themselves and/or at risk of harming others.

3. This research is intended to help to inform the planning and provision of services at a local level across Scotland, to ensure the safety of this vulnerable group, while at the same time reducing any unnecessary burden on emergency services.

Chapter 2 – Methods

4. The study made use of both qualitative and quantitative methods. Secondary data from the police and NHS was analysed to identify the size and nature of the problem facing emergency services in Scotland. A literature review was carried out to explore how the needs of this population are met in other parts of the world, and to identify good practice in providing services. Interviews were also undertaken with stakeholders and service providers in Scotland, and a survey was carried out of all Alcohol and Drug Action Teams (ADATs), to identify any existing services and the need for services in Scotland. Finally, focus groups were undertaken with service users to obtain their perspectives on the need for services.

Chapter 3 – Identifying the size and nature of the problem

5. An analysis of emergency department data, hospital inpatient data and police data was undertaken to estimate the need for services for drunk and incapable people in Scotland.

6. Based on emergency department data, it is estimated that between 7,500 – 21,000 people per year (144 – 404 people per week) are currently presenting to NHS emergency departments as drunk and incapable, whose needs could potentially be met by a less resource-intensive service. At an average cost of £93 per attendance, the cost of treating these individuals in an emergency department is estimated to be between £0.7m and £1.95m per year.

7. According to hospital inpatient data from 2006-07, acute intoxication was the primary diagnosis for 1,440 patients across Scotland. This is equivalent to...
approximately 28 people per week. Although this is a relatively small number of people, the average daily cost of an acute hospital bed is £483. Therefore, the cost associated with 1,440 intoxicated patients having an overnight stay in hospital is approximately £0.7m per year.

8. In 2007-08, there were 5,502 charges made by Scottish police forces to individuals for being drunk and incapable. This is equivalent to approximately 106 charges per week. The cost of holding these individuals in police cells is estimated to be around £2.12m per year across Scotland.

9. Note that there may be overlap between the emergency department, hospital inpatient and police datasets (for example one person may attend hospital and also be charged with being drunk and incapable). Therefore, it is not possible to add up the costs from the different services to get an overall estimated cost.

10. This study suggests that people who become severely intoxicated in public are a diverse population. Stakeholders identified three groups: (i) "one-offs" who have drunk to excess on a night out, who present to services once and never appear again; (ii) "binge drinkers" who are not alcohol dependent, but who will regularly consume large amounts of alcohol on weekends or special occasions, and who may present to services more than once; (iii) chronic, "recidivist" drinkers who are alcohol-dependent and who may present to services on multiple occasions. The immediate needs of all three groups are the same — to be kept safe. However, once they are sober, those who are not alcohol-dependent may benefit from brief interventions to encourage a reduction in drinking, whereas people with chronic drink problems may have additional, and more complex health and social care needs.

Chapter 4 – International review of the literature

11. A review of the international literature identified a variety of service models from around the world that are used to meet the care needs of severely intoxicated people.

12. Sobering-up facilities were common in Australia and parts of North America, and there was evidence from Australia of these services providing clients with physical and emotional care, support and brief interventions. They were perceived to be safer, and a better use of resources, than holding intoxicated people in police custody.

13. There is no single best-practice model for these services. However, it is important that services are developed directly in response to local needs and that they remain flexible when needs change. It is also important that there are clear operational protocols and procedures that are agreed with the police and local health services. Staff should be trained in first-aid, and there should be good links with rehabilitation, housing and social care services.

14. Free transportation services operating in conjunction with sobering-up services can further reduce the burden on the police of having to deliver intoxicated people to these services.
15. There was a small literature on the role of the forensic medical examiner (FME) and custody nurses in providing care for people detained in custody. A large part of the job of the FME and custody nurse involves assessing the fitness of people to be held in custody.

16. Finally, one model of service which is used increasingly to meet the needs of drunk and incapable people in the UK, involves the use of a bus. These “SOS buses” provide immediate assistance to people who may be intoxicated, distressed or have minor injuries. They offer first-aid (including, in some cases, social and emotional first-aid), and in some cases, a place of safety for people until they are able to be taken home by a family member, friend or taxi. These services are largely based in busy, city-centre locations. Most operate only at the weekends or during special events.

Chapter 5 – Services in Scotland

17. In most areas of Scotland, people who are identified as drunk and incapable in public are ordinarily taken into police custody for their own safety, if there is no responsible person available to look after them. If they have sustained an injury, they are usually taken to the nearest emergency department.

18. However, in some areas of Scotland, services had been established to address the needs of drunk and incapable people, while also reducing the excessive burden on emergency services.

19. The main types of services were: (i) permanent premises providing a 24-hour service, seven days a week (Inverness and Aberdeen); (ii) temporary triage or first-aid facilities operating at weekends or for special events (Glasgow, Edinburgh and Aberdeen); and (iii) other services such as custody nurses, police and ambulance protocols, and cell monitoring systems.

20. Some services, such as the designated places in Inverness and Aberdeen, attempt to engage with clients and offer advice, information, and in some cases, referrals to other services. There is less opportunity for this kind of intervention in the other types of services but there was a view that there should be some attempt to offer brief interventions, or in the case of chronic drinkers, referral to services that can address their longer-term care needs.

21. Service users unanimously agreed that if a person is drunk, but not violent, there should be other options than being taken into custody. For service users, the preferred option would be for the intoxicated person to be taken home, or to be able to phone a contact person to come and collect them from the police station. However, there was broad support for the idea of making a very basic facility available to look after people in this condition. Service users also believed it was important that some form of follow-up should take place once a person is sober — to offer advice, information or referral to treatment and support.

Chapter 6 – Conclusions and recommendations

22. The data gathered for this study provides a useful starting point for local areas in planning services for drunk and incapable people. However, the findings of
this study do represent just a starting point. It is important that local areas supplement this information with locally-gathered intelligence to gain a more comprehensive and detailed picture of local need.

23. The findings of this study suggest that a one-size-fits-all approach to services for drunk and incapable people is unlikely to address all the needs. Therefore, this study does not recommend that local areas should adopt a certain model of service. Different service models have different strengths and limitations, and it may be that the best approach will be a combination of models.

24. Severely intoxicated people are vulnerable to injury, assault or illness. These individuals need to be taken to a place or facility where their health and safety can be monitored effectively. Police cells are not appropriate for the care of vulnerable people and many of these individuals do not require to attend emergency departments or to be admitted to hospital.

25. There needs to be an alternative service, or alternative services, to reduce the pressure on the time and resources of the emergency services. Arrangements also need to be made to assess and monitor the needs of alcohol-related detainees, and this task should be performed by appropriately trained staff.

26. The following recommendations are made:

- There should be a strategic and partnership approach at local level to planning and funding services to meet the care needs of drunk and incapable people.

- The findings of this study suggest that in some local areas, there have been difficulties agreeing who should take responsibility for planning and delivering services for drunk and incapable people. In our view, the strategy for addressing the care needs of drunk and incapable people should be part of a wider local alcohol strategy, and Alcohol and Drug Partnerships are therefore best placed to take the lead on this.

- Local areas should undertake a local area needs assessment prior to planning services for drunk and incapable people. Locally-gathered intelligence may provide a more comprehensive and detailed picture than it has been possible to provide here.

- The provision of services requires the involvement of a range of agencies but should include at the very least, health, social work, the police, the ambulance service and the voluntary sector. There are potential cost savings to be made in shifting the balance of care from high-resource-intensive emergency services to services that are specifically targeted at this population.

- At the same time, the NHS, in particular, should take a much greater role in the establishment and running of services than they do at present in some areas. NHS input is needed not only to address people’s acute care needs
when they are intoxicated, but also the longer-term care needs of alcohol-dependent people.

- Local strategies for responding to the needs of drunk and incapable people should include interventions that help to prevent people from becoming drunk and incapable in the first place. Examples of the use of taxi marshals and the Street Pastor initiatives around Scotland are perceived to be beneficial and should be considered more widely.

- Some people will have to be detained in custody because of the other offences they have committed. The care needs of these individuals should be assessed and met by a suitably trained individual.

- At the same time, the use of technology, for example through cell monitoring systems, may provide an additional (not an alternative) support for monitoring intoxicated people in custody.

- Protocols should be developed between the police, ambulance service, emergency department and any alternative services set up to manage the care needs of intoxicated people. These protocols should clearly specify the target group for the alternative services, how people are referred to them, how the services operate, and how they can make referrals to other agencies to address longer-term care needs.

- Finally, services need to have an effective way of linking people to treatment and support. However, commissioners and planners should discuss with service providers realistic aims and objectives for meeting the immediate care needs of clients and whether, and how, that can be combined with further intervention with those people who have chronic alcohol problems.
1 INTRODUCTION

1.1 This is the final report of a research study commissioned by the Scottish Government and conducted by Griesbach & Associates between June and November 2008. The purpose of the study was to improve information and evidence about the most effective ways to manage the care needs of drunk and incapable people in Scotland.

1.2 The term “drunk and incapable” is used to refer to persons who are intoxicated to such a level that it is impossible for them to look after themselves. Thus, these individuals are vulnerable and at risk of harm to themselves and/or at risk of harming others.

1.3 This research is intended to help to inform the planning and provision of services at a local level across Scotland, to ensure the safety of this vulnerable group, while at the same time reducing any unnecessary burden on emergency services.

1.4 It is important to note here that this research was not an evaluation of the effectiveness of existing services for drunk and incapable people in Scotland. The focus was on establishing the nature and scale of the need for services and identifying different models of services that might meet that need, taking into account evidence of good practice.

Background and context

1.5 Alcohol consumption and excessive drinking are increasing in Scotland. Figures on consumption published in a Scottish Government discussion document indicate that up to 50% of men and 30% of women in Scotland currently exceed weekly recommended sensible drinking guidelines, and that a majority of drinkers exceed daily guidelines at least once a week.¹

1.6 When an individual has drunk so much that they become incapable of looking after themselves — or if they become unconscious — emergency services are frequently involved. In many cases, the person spends a night in police cells to sleep it off. However, such people need to be monitored for their own safety because of the risks of alcohol poisoning, choking on vomit or suffocating, or because they may have undetected medical conditions or serious head injuries. This is widely regarded as an inappropriate use of police time, however these measures are necessary to prevent alcohol-related deaths while in police custody.

1.7 In Scotland, there has been a general decline in deaths in police custody since 1995/96. In that year, there were 17 deaths and this figure fell to four in 2000/01.² However, deaths in police custody have been slowly rising again,  

and in 2005/06, there were eight deaths. A Home Office Report published in 1998 highlights the significant role that alcohol (or apparent drunkenness) can play in these deaths.

1.8 People who become severely intoxicated in public are also often taken (by the police, or by ambulance) to hospital emergency departments because of alcohol-related injury (from an accident or an assault). However, sometimes they are only intoxicated and simply need time to sober up. Again, the use of emergency services for this purpose is widely considered to be inappropriate. Moreover, intoxicated people in hospitals can often be severely disruptive, abusive or even violent.

Costs

1.9 Figures published by the Scottish Government estimate that alcohol misuse costs the Scottish economy £2.25 billion annually. Approximately 20% of this cost (£449 million) relates to costs incurred by emergency and criminal justice services (police, emergency department, ambulance, fire brigade) in responding to demands placed upon them by people who have drunk too much. Clearly, excessive drinking represents a significant burden on the emergency services and diverts them away from people who may require their services more urgently.

Legal context

1.10 The Criminal Justice (Scotland) Act 1980 first introduced the concept of a “designated place”. Part I, Section 5, paragraph 1 of the Act states:

Where a constable has the power to arrest a person without a warrant for any offence and the constable has reasonable grounds for suspecting that the person is drunk, the constable may, if he thinks fit, take him to any place designated by the Secretary of State as a place suitable for the care of drunken persons.

1.11 Strictly speaking, this Act does not decriminalise public drunkenness, but rather empowers the police to use discretion in dealing with those arrested for an offence where the arrestee is intoxicated. The term “designated place” was used again in the Criminal Procedure (Scotland) Act 1995 (Section 16(1)), and paragraph (2) of Section 16 made clear that the use of such a place as an alternative to custody does not necessarily preclude the drunken person being charged with an offence.

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1.12 Although this legislation has been available for some time, the development of “places suitable for the care of drunken persons” has been slow in Scotland. Albyn House in Aberdeen and Beechwood House in Inverness both have the official status of “designated places” and have been in existence for a number of years. However, a wider network of designated places across Scotland has not materialised.

1.13 In practice, large numbers of people continue to be charged with the offence of being drunk and incapable in public. Because of the lack of alternative services, these individuals are generally arrested and placed in police custody for their own protection, then released when they are sober enough to look after themselves. Individuals charged with being drunk and incapable should normally be reported for summons. However, procurators fiscal generally do not pursue such cases, and charges are frequently dropped before court proceedings occur. The implications of this are that the police are effectively performing a care function for these individuals, rather than enforcing the law or pursuing justice.

1.14 Precisely this point was made in a report by HM Inspectorate of Constabulary (HMIC), which highlighted concerns by the police that police cells are not the best place to hold people who are “merely drunk and incapable of looking after themselves”. The report also noted that police personnel can only have limited skills in identifying, assessing and caring for people who may have medical conditions or whose drunkenness can mask other more serious conditions. The report argued that police should no longer be expected to take the primary role in looking after drunk and incapable people, but that an alternative approach needs to be found to tackle the health and social care needs of this group.

**Policy context**

1.15 More recently, the Scottish Government’s discussion paper, *Changing Scotland’s relationship with alcohol*, made a commitment to work with partners to identify the scale of the problem of drunk and incapable people requiring emergency support, to evaluate existing models of providing that support and to identify good practice. The commissioning of this research was part of the fulfilment of this commitment.

**Aims of the research**

1.16 The aim of this research, as specified by the Scottish Government, was to deliver a set of conclusions and recommendations on how best to manage

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7 Albyn House was established in 1983 and Beechwood House was established in 1990.
people who are drunk and incapable to help alleviate the unnecessary pressure on emergency services.

1.17 The objectives were to:

- Undertake a review of the literature to describe the scale of the problem in Scotland.
- Gather information from the published literature and reports about how designated places of safety operate in other countries.
- Map existing services in Scotland (including the number and profile of people using these services) and describe how they operate including whether and how they offer access to treatment and support.
- Analyse data from a variety of services (ambulance, police, emergency departments) to estimate the number of people in Scotland who could potentially benefit from services.
- Identify different models of support, both in Scotland and elsewhere, to establish the key elements of successful approaches.

1.18 The aims and objectives of this study can be summarised by four research questions:

1. What need is there for services for drunk and incapable people in Scotland?
2. What do services look like that exist to manage the needs of drunk and incapable people, in Scotland and elsewhere?
3. What is considered to be good practice in providing for the needs of drunk and incapable people?
4. What are the best options for providing such services?

Structure of this report

1.19 This report has six chapters.

- Chapter 2 provides information about the methods used to conduct the research.
- Chapter 3 answers the question: what need is there for services for drunk and incapable people in Scotland?
- Chapter 4 answers the question: what do services in other countries looks like, and what is considered to be good practice in providing for the needs of drunk and incapable people?
- Chapter 5 describes the services we identified in Scotland, and provides information about stakeholders’ views on what works well in those services.
- Chapter 6 discusses the findings, presents conclusions and makes recommendations based on the evidence gathered.
2 METHODS

2.1 To answer the four research questions, it was necessary to use both quantitative and qualitative methods. These involved:

- An analysis of secondary data from police and NHS sources – to examine the size and nature of the problem facing emergency services
- A literature review – to describe service provision and good practice internationally
- A survey of all Alcohol and Drug Action Teams (ADATs) in Scotland – to identify existing services and the need for services across Scotland
- Interviews (telephone and face-to-face) with stakeholders and service providers operating designated places, or other services for drunk and incapable people – to describe current service provision in Scotland and identify good practice
- Focus groups with service users – to obtain their perspective on the need for services.

2.2 A research advisory group, comprising key stakeholders, was established to provide advice and guidance and to facilitate access to relevant data during the course of the research.

Analysis of secondary data

2.3 Currently it is mainly the emergency services that respond to the problem of drunk and incapable people. We therefore focused our search for data on the emergency services, specifically the police and ambulance services and the NHS.

2.4 As far as possible, we sought to analyse the data to describe the nature and characteristics of people who are drunk and incapable and their presentation to services. Ideally, we wanted to analyse information on:

- The characteristics of people who are drunk and incapable: their age, gender, ethnicity, disability, age, housing status, local authority (or ADAT) area, whether they committed a crime (and type of crime), drinking patterns (e.g., alcohol dependent or binge drinker)
- The characteristics of the presentation: location, times and days of arrest / ambulance attendance / hospital presentation, local authority or ADAT area.

2.5 In practice, we found that much of this data was not available. For example, an attempt was made to gather data from the Scottish Ambulance Service. However, the Ambulance Service does not, as yet, collect data on the number of call-outs for people who are drunk and incapable, though there are plans to improve data collection in this area. Another example is that none of the agencies we contacted collected data on whether people who were drunk and incapable had a disability.
2.6 In relation to the collection of police data, following discussions with a data analyst at Central Scotland police, it was decided that the most consistent and easily retrievable measure of the numbers of drunk and incapable people dealt with by the police, would be the number of recorded charges of people for being drunk and incapable. Being drunk and incapable without a responsible person present is an offence under the Civic Government (Scotland) Act 1982. All Scottish forces and the Scottish branch of the British Transport Police provided data on the numbers and characteristics of charges for this offence in 2007-08. It should be noted that not all forces in Scotland have the same policy with regard to charging drunk and incapable people. This is explained further in Chapter 3 (paragraph 3.44).

2.7 The NHS collects a variety of data on people with alcohol-related diagnoses. For the purposes of this research, the most useful source of data was the number of people discharged from acute hospitals with a diagnosis of alcohol intoxication. The NHS Information Services Division (ISD) provided this data for 2006-07, the latest year for which data was available.

2.8 In addition to the hospital discharge data, we specifically wanted to identify the size of the problem faced by emergency departments. However, there is currently no central recording of presentations to emergency departments in Scotland unless the presentation resulted in admission. Moreover, individual emergency departments do not routinely record whether attendances are alcohol-related. We therefore made use of data collected in 2005 by NHS Quality Improvement Scotland (QIS) during a ten-day audit of hospital emergency departments in Scotland. The purpose of the audit was to determine the scale and nature of alcohol-related presentations. The sample included 15 emergency departments in all of Scotland’s major cities apart from Dundee. It also included three hospitals (in Highland and Ayrshire & Arran) which serve large rural areas. None of the island hospitals were included in the study.

2.9 QIS provided raw data from this audit on the number and characteristics of people presenting to emergency departments with alcohol intoxication.

2.10 Another useful source of information was the ISD Alcohol Information Scotland website, which provided contextual information on trends in alcohol consumption and alcohol-related harm.

2.11 None of these sources of data gave us a complete picture of the number of drunk and incapable people in Scotland. Each set of data was for a different service and a different year and because there is potential overlap between the datasets (for example a person may both attend a hospital and be charged with being drunk and incapable) it is not possible to ‘add up’ the numbers from the different services to get an overall number for Scotland. However, the data does provide a good picture of the impact of ‘drunk and incapable’ or

‘intoxicated’ people on the different services they use and therefore helps to identify the level of need.

2.12 Further explanatory notes on the secondary data are provided in Appendix A.

Literature review

2.13 The aims of the literature review were:

- To identify services that exist in other countries (outside of Scotland) to manage the needs of drunk and incapable people, and
- To identify good practice in providing these services.

2.14 This was a review of the international, English-language literature on the provision of sobering-up services and other similar services. The main focus was on services that aim to meet the immediate (rather than long-term) care needs of people who are identified as drunk and incapable, and which divert these individuals from the criminal justice system.

2.15 Bibliographic databases including EMBASE, MEDLINE, PsycINFO were searched using the following search terms: sobering(-up) services / facilities / centres; drunk tanks; detoxification centres; nurse + custody; drunk and incapable; inebriate / chronic public inebriate. In addition, an internet search (using Google) was also undertaken using the same, or similar, search terms.

2.16 The collected material was a combination of published journal articles, government reports, unpublished research reports, news articles and descriptions of services taken from local government or local health authority websites from around the world.

Surveys and interviews

2.17 A short online survey was conducted of all ADATs in Scotland to identify the range and scope of current services available for drunk and incapable people and future plans for such services at a local level.

2.18 An initial survey showed that a greater number of areas than anticipated had some form of service which attempted to address the immediate care needs of drunk and incapable people. These services were:

- Designated places – Aberdeen and Inverness
- Temporary / triage facilities – Glasgow, Edinburgh and Aberdeen
- Custody nurses – Edinburgh
- Ambulance / police protocols – Fife and Edinburgh

2.19 Other areas had well-advanced plans for some type of service for drunk and incapable people. These included a crisis service in Shetland and custody nurses in Forth Valley. In addition, Aberdeen, Edinburgh, Fife, Lanarkshire
and Glasgow were considering how to develop services for drunk and incapable people in the future.

2.20 In the areas where there were existing or planned services, the initial survey was followed up through telephone or face-to-face interviews with service managers or co-ordinators to explore the operation of the services and changes over time. We also interviewed 30 local stakeholders in these areas to get their perspective on the services and on future needs. Stakeholders included representatives of the NHS / emergency departments, police, social work and the Scottish Ambulance Service.

2.21 Specifically, the interviews explored:

- How well the service meets the needs of drunk and incapable people
- Links to treatment
- Which of the emergency services benefits most (from having the service)
- The client group and how it has changed over time
- The impact of the service
- What works well and what could be done differently
- Whether there are unmet needs
- Whether there are any future plans regarding service development.

2.22 In addition we asked people managing services for drunk and incapable people for data on their users so that we could examine their characteristics, for example, in relation to age, gender, referral route, and time and day of presentation.

2.23 To explore views about the need for services in the ADAT areas where there were no existing or planned services, we conducted a second on-line survey to investigate whether a need had been identified and, if so, why it had not been possible to address that need to date.

Focus groups with alcohol service users

2.24 Finally, to get the perspectives of service users, two focus groups were undertaken with clients of two alcohol community rehabilitation services in Glasgow. One was a group of women (n=9), ranging in age from mid-20s to late-50s. The second (n=8) was predominantly a group of men (this latter group included one woman), ranging in age from mid-20s to mid-60s.

2.25 The majority of the participants in both groups had had one or more experiences of being arrested by the police and taken into custody for being drunk and incapable in public.

2.26 During the discussion, participants were asked their views on the current situation whereby people who are found drunk and incapable are generally taken into custody for their own protection. They were also asked what they
think *should* happen with people in this situation, and specifically, whether they felt it would be helpful to provide a safe place (outside of police cells) where intoxicated people could be taken to sober up.
3 THE NEED FOR SERVICES

Summary of main points

- This section investigates the need for services for drunk and incapable people in Scotland. This is done by examining data from Scottish NHS hospitals (emergency departments and in-patient discharges), the police, and other services which specifically address the needs of drunk and incapable people.

Emergency Department attendances

- It is estimated that between 7,500 – 21,000 people per year (144 – 404 people per week) are currently presenting to NHS emergency departments as drunk and incapable, whose needs could potentially be met by a less resource-intensive service. At an average cost of £93 per attendance, it is estimated that the financial cost of drunk and incapable people attending emergency departments in Scotland is between £0.7m and £1.95m per year.

Hospital inpatient discharges

- In 2006-07, 7,019 patients were discharged from Scottish NHS acute general hospitals with a diagnosis of acute alcohol intoxication. However, acute intoxication was the primary diagnosis for 1,440 patients, which is equivalent to approximately 28 people per week. Although this is a relatively small number of people, the average daily cost of an acute hospital bed is £483. Therefore, the cost associated with 1,440 intoxicated patients having an overnight stay in hospital is approximately £0.7m per year.

Police data on drunk and incapable charges

- There were 5,502 charges made by Scottish police forces in 2007-08 to individuals for being drug and incapable. This is equivalent to approximately 106 charges per week. The cost of holding these individuals in police cells is estimated to be around £2.12m per year across Scotland.

Other services

- Scotland currently has two designated places, Beechwood House in Inverness and Albyn House in Aberdeen. In 2007-08, Beechwood House received 1,100 referrals (of which 199 were refused), and Albyn House had 686 admissions. A relatively large proportion of admissions to Beechwood House and Albyn House are repeat admissions of people who have attended the service previously.

Profile

- People who become drunk and incapable are not a homogenous group. In interviews with stakeholders, it was suggested that there are broadly, three groups: (i) “one-offs” who have drunk to excess on a night out, who present to services once and never appear again; (ii) “binge drinkers” who are not alcohol dependent, but who will regularly consume large amounts of alcohol on weekends or special occasions, and who may present to services more than once; (iii) chronic, “recidivist” drinkers who are alcohol-dependent and who may present to services on multiple occasions. The immediate needs of all three groups are the same — to be kept safe. However, people with chronic drink problems may have additional, and more complex health and social needs.
3.1 One of the main questions this study has sought to answer is: what need is there for services for drunk and incapable people in Scotland? This chapter attempts to answer this question by examining both quantitative and qualitative data from a variety of sources.

3.2 The aim of gathering quantitative data was to describe the characteristics of drunk and incapable people in Scotland, in terms of their age, gender, ethnicity and housing status, and then to estimate the overall size of the problem across Scotland and at a local level. The focus was on identifying the likely demand for services in particular areas, and more specifically, on identifying the number of drunk and incapable people who could potentially be diverted from police custody or whose needs could be met by a service other than a hospital emergency department.

3.3 The aim of gathering qualitative data was to describe the nature of the need for services and whether and how those needs were currently being met.

3.4 The information presented in this chapter draws on: (a) secondary data collected from NHS hospitals, the police and current providers of services for drunk and incapable people; and (b) the perspectives of service managers and local stakeholders, including ADAT representatives, the NHS, police, social work, Scottish Ambulance Service and service users.

**Intoxicated people presenting to emergency departments**

3.5 First, this section will examine data on alcohol-related presentations to Scottish emergency departments. As mentioned in Chapter 2, this data was collected by NHS QIS during an audit conducted in 15 emergency departments during a randomly selected ten-day period in 2005. Alcohol-related presentations included the patient reporting they had been drinking prior to attendance at the hospital, the smell of alcohol on the person’s breath or signs of intoxication. It also included patients who reported that another person’s use of alcohol had contributed to their attendance, e.g., the patient may have been the victim of an assault by someone who had been drinking.

3.6 During the ten days, a total of 21,214 patients attended the 15 emergency departments.\(^{12}\) Alcohol was considered to be contributory factor in 2,228 presentations (11%), although the authors of the audit report acknowledged that this was likely to be an underestimate, as hospital staff can sometimes be reluctant to document alcohol consumption when it is not seen as being relevant to the patient’s management.\(^{13}\)

3.7 Trauma was the most common condition among patients in this group — just over half (53%) of patients for whom alcohol was a contributory factor had

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sustained some form of injury. However, alcohol intoxication was found to be the next most common presenting condition: 506 patients (23% of all alcohol-related presentations) were intoxicated when they attended the emergency department. This group comprised 2.4% of all emergency presentations during the ten-day audit. It is perhaps worth noting that psychiatric conditions were the third most common reason for attendance among patients for whom alcohol was a contributory factor (15%), and that gastro-intestinal, cardiac and respiratory conditions were present in fewer than 10% of all alcohol-related attendances.

3.8 Of the 506 patients who presented as intoxicated, 130 (26%) had no other presenting condition. In other words, they were just drunk, although there is no information about the severity of intoxication. This group comprised 0.6% of all emergency presentations during the 10-day audit. Figure 3.1 provides a schematic representation of this data.

**Figure 3.1: Alcohol-related presentations at 15 emergency departments (EDs) during a 10-day audit conducted by NHS QIS in 2005**
3.9 The findings of the audit showed considerable variation in these proportions from one hospital to another. That is, some emergency departments had a greater proportion of intoxicated presentations than others, suggesting that the problem of public drunkenness is not evenly distributed across Scotland. In addition, as mentioned above in paragraph 3.6, there may also be an issue with inconsistency of coding among hospital staff.

**The nature of intoxicated presentations to emergency departments**

3.10 Across the 15 emergency departments, the majority (70% or more) of intoxicated presentations were men (data not shown). However, in Edinburgh, Inverness and some of the Glasgow hospitals, a third or more of intoxicated presentations were females. There was a higher proportion of intoxicated presentations among those aged 20-29 and 40-49 than among other age groups; the lowest proportion was among the over-70s.

3.11 Intoxicated people were most likely to present between 10pm and 8am on any night of the week. The lowest numbers of intoxicated presentations were in the mornings between 8am and 1pm. Not surprisingly, across all 15 emergency departments, the peak periods for intoxicated presentations were on Friday and Saturday nights between 10pm and 8am (data not shown).

3.12 Of the 506 intoxicated presentations to emergency departments during the audit, 344 (69%) were not admitted to hospital. These 344 patients comprised 1.6% of all emergency department attendances during this period. In addition, of the approximately one-third who were admitted, more than two-thirds of these were admitted for one day or less. See Figure 3.2 below.

**Figure 3.2: Admission status and length of stay of intoxicated people attending emergency departments (EDs) during a 10-day audit in 2005**

<table>
<thead>
<tr>
<th>Number of people presenting to EDs as intoxicated</th>
<th>506</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number admitted to hospital</td>
<td>157 (31%)</td>
</tr>
<tr>
<td>Number of people not admitted</td>
<td>344 (69%)</td>
</tr>
<tr>
<td>Number of people admitted for one day or less</td>
<td>107 (69%)</td>
</tr>
<tr>
<td>Number of people admitted for two days or more</td>
<td>48 (31%)</td>
</tr>
</tbody>
</table>

Notes to figure: Admission status was not recorded for five patients. Length of stay was not recorded for two patients.
3.13 No information is available about why some intoxicated individuals were admitted to hospital and others were not. On the one hand, it might be assumed that those who were admitted had more serious medical conditions that required an overnight stay. However, this assumption is not necessarily valid. Some individuals (including those for whom intoxication was their only presenting condition) may have been admitted simply because there was no one into whose care they could be discharged, while others (including those who had suffered trauma) may have been sent home because there was someone at home who could look after them.

**Estimating the number of intoxication-related emergency department attendances**

3.14 So far, the data presented on intoxication-related emergency department attendances has come from a small sample of emergency departments during a short 10-day period in 2005. To get a more accurate picture of the impact of drunk and incapable people in emergency departments across Scotland, it is necessary to extrapolate this information to other emergency departments, and over a longer period of time.

3.15 Extrapolation is based on a number of assumptions, first that the 10-day period in which data was collected is representative of presentations during the longer period; and second that the attendances recorded at the 15 participating hospitals are representative of attendances at hospitals across Scotland. In this case, it could be argued that the second assumption is not valid, because as stated in paragraph 3.9, there was considerable variation in the number and nature of alcohol-related attendances at the 15 hospitals. Any estimate obtained through extrapolation therefore needs to bear in mind this significant caveat.

3.16 Data obtained from NHS QIS shows that, in all hospitals across Scotland there were just under 1.5 million emergency department attendances in the one-year period from April 2005 – March 2006.14 However, many of these were attendances at small cottage hospitals where emergency department-type services may operate only during office hours. The attendance of intoxicated people at these hospitals would depend on a number of factors, including the mode of arrival (ambulance calls would ordinarily be sent to the nearest major emergency department), rurality, time of day, and a variety of other unknowns. It is therefore likely that the prevalence of intoxicated presentations at these hospitals is lower than the prevalence found in the QIS audit.

3.17 Therefore, small cottage hospitals have been largely excluded in calculating the estimates below. However, we included a small number of cottage hospitals in the NHS Highland area, which all have 24-hour emergency department services and which reported more than 5,000 emergency department presentations in the year 2005-06. These hospitals also serve large rural areas — often being the only hospital within a 2-3 hour drive.

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14 The period April 2005 – March 2006 corresponds to the year in which the QIS audit took place.
3.18 We also excluded emergency departments in children’s hospitals and minor injuries units (which exist alongside of, or instead of, emergency departments in some hospitals). Both of these are likely to receive intoxicated presentations. However, as the QIS audit did not include children’s hospitals or minor injuries units, there is no reliable information about the prevalence of intoxicated presentations in them.

3.19 Thus, our estimate of the scale of the problem of intoxicated presentations in emergency departments is based on approximately 1.26 million presentations in 33 hospitals. Assuming that, as in the QIS audit, 2.4% of all emergency department attendances were of intoxicated people, it is estimated that there were a total of 30,222 intoxication presentations in emergency departments across Scotland in 2005-06. (A breakdown of this estimate by NHS Board area is provided in Table B.1 in Appendix B.) The actual figure is likely to be higher since, as explained above, intoxicated presentations at small cottage hospitals, children's hospitals and minor injuries units have been excluded from the calculation.

3.20 The estimated number of intoxicated presentations, 30,222, does not represent the number of people whose needs might be met by a service other than a hospital emergency department. For example, some intoxicated patients will have other conditions that require treatment within an emergency department. Some will need to spend one or more nights in hospital.

3.21 However, we would suggest that intoxicated patients with no other presenting conditions may be eligible to have their needs met by a service other than an emergency department. In addition, we would also suggest that a certain proportion of intoxicated people who have other presenting conditions (including less serious trauma injuries) may be another group who could potentially have their needs met by a service less resource-intensive than a hospital emergency department.

3.22 To estimate the number of people who may fall into these two groups, we used the following proportions derived from the NHS QIS data:

- 0.6% of all emergency department attendances were of intoxicated people who had no other presenting condition. (See again Figure 3.1.) Based on the total emergency department presentations (1.26m), this equates to about 7,500 people (data not shown) — or 144 people per week across Scotland.

- 1.6% of all emergency department attendances were of intoxicated people who were not admitted to hospital. (See again Figure 3.2.) This equates to approximately 21,000 people (data not shown) — or 404 people per week across Scotland.

3.23 Using these calculations, we estimate that there are between 7,500 – 21,000 people per year (or 144 – 404 people per week) across Scotland who are currently presenting to emergency departments, but whose needs could more appropriately be met by a network of services for drunk and incapable people. (See Table B1 in Appendix B for estimates by health board).
3.24 Using information from the Scottish Health Services Cost Book, we can also calculate the cost to the NHS of drunk and incapable attendances to emergency departments.\(^{15}\) As the average cost of an emergency department attendance in Scotland is £93, the financial cost of drunk and incapable people attending emergency departments is therefore between £0.7m and £1.95m per year.

3.25 It is important to note that there is likely to be some double-counting in these estimates. For example, some of the 1.6% of people who were not admitted to hospital will almost certainly also be included in the 0.6% of people who presented as intoxicated with no other presenting condition. Nevertheless, given that both these figures are likely to under-estimate the true size of the problem, it could be argued that these two figures taken together provide a useful upper and lower estimate for the size of the problem faced by emergency departments in Scotland.

**Intoxication-related NHS hospital inpatient discharges**

3.26 If the intention is to provide services to drunk and incapable people that meet their needs, while reducing the burden on emergency services, it may be expected that data from hospital emergency departments will provide a better indication of the likely demand for these services than hospital inpatient statistics. If an intoxicated patient requires admission to hospital, this may be because of a co-occurring medical condition (head injury, alcohol poisoning, heart condition) which requires clinical monitoring, and which, therefore, would make the patient ineligible for a non-clinical (or less clinical) service.

3.27 However, in our interviews with stakeholders across Scotland, it was reported that some intoxicated people may be kept in hospital simply because there is no where to send them to sober up where their condition can be monitored.

3.28 We have therefore examined hospital discharge data (provided by the NHS Information Services Division) for the year 2006-07, the latest year for which data was available. Hospital discharge data provides information on the number of people who have been admitted to hospital (for at least one night) and then discharged. We have focused specifically on discharges where there was a primary diagnosis of acute alcohol intoxication. The purpose is to ascertain whether this data adds any useful information to the picture we already have in relation to emergency department attendances.

3.29 In 2006-07, there were just over one million inpatient discharges from Scottish NHS acute general hospitals. Of these, 7,785 had a diagnosis of acute alcohol intoxication. These 7,785 discharges involved 7,019 patients — or 1.1 discharges per patient, suggesting that there were few repeat admissions of individuals with a primary diagnosis of acute intoxication in this period.

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\(^{15}\) The Scottish Health Services Cost Book is an annual publication containing data on the cost of providing health care in Scotland. The data is compiled by the NHS Information Services Division (ISD), and it available at: [www.isdscotland.org/isd/costs-book.jsp](http://www.isdscotland.org/isd/costs-book.jsp). Information on the average cost of an emergency department attendance is provided in the Executive Summary.
3.30 The majority of discharges were male. However, in some of the rural areas (Shetland, Dumfries & Galloway, Argyll & Bute and Eilean Siar) females comprised more than 30% of discharges. (Data shown in Tables B.2 and B.3 in Appendix B.) Females also comprised 30% of intoxication-related discharges in Edinburgh City.

3.31 In nearly 80% of patients, acute intoxication was a secondary diagnosis to one or more other presenting conditions. However, acute intoxication was the primary diagnosis for 1,440 patients. Across Scotland, this represents 21% of all patients who had a diagnosis of acute intoxication, and is equivalent to approximately 28 people per week. See Figure 3.3 below.

3.32 Twenty-eight people per week across Scotland would seem to represent a relatively small demand for services. However the proportion of intoxicated patients with a primary diagnosis of acute intoxication varied from one area to another (data not shown). Moreover, according to the Scottish Health Services Cost Book, the average cost per day of an acute hospital bed is £483. Therefore, the cost associated with 1,440 intoxicated patients having an overnight stay in hospital can be estimated at approximately £0.7m per year.

Figure 3.3: Number of discharges / patients with a diagnosis of acute alcohol intoxication, 2006-07

Approx 1.1 million
Number of discharges from NHS acute general hospitals in 2006-07.

7,785
Number of discharges with a diagnosis of acute alcohol intoxication.

7,019
Number of patients

1,089,383
Number of discharges without a diagnosis of acute alcohol intoxication.

21% of patients with a diagnosis of acute intoxication had a primary diagnosis of acute intoxication

1,440
Number of patients with a primary diagnosis of acute alcohol intoxication

5,579
Number of patients where acute intoxication was a secondary diagnosis

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16 See the Scottish Health Services Costs Book, Report R040 at: [www.isdscotland.org/isd/4434.html](http://www.isdscotland.org/isd/4434.html)
3.33 It is suggested that some of the 1,440 patients who had a primary diagnosis of acute intoxication may have been able to have their needs met through another service, rather than through a stay in hospital. However, without knowing: a) their other diagnoses (if any), and b) the severity of their intoxication, it is difficult to estimate more precisely.

3.34 In any case, the inclusion of this group of people would not seem to significantly alter the estimates we have made using emergency department data only. (See again paragraphs 3.22 and 3.23 above.)

**Scottish Ambulance Service**

3.35 As mentioned in Chapter 2, there is no national data available on alcohol-related ambulance call-outs. Data provided by the Scottish Ambulance Service (SAS) for the Scottish Government’s discussion paper, *Changing our relationship with alcohol*, indicated that in 2007, SAS attended an average of 73 incidents in Glasgow between 1-2am on Sunday mornings, compared with the normal hourly average of 38 incidents. On Hogmanay, there were 150 incidents in the hour between 2.00am – 3.00am.

3.36 It is not known how many of these incidents were alcohol-related. However, it seems reasonable to assume that a substantial number of them were. The nature of the impact of drunk and incapable people on the SAS was explored in more detail in interviews with SAS staff. This information will be discussed later in this chapter.

**Police data on drunk and incapable charges**

3.37 Finally, the other emergency service which deals with large numbers of drunk and incapable people is the police. Drunkenness offences recorded in Scotland are in decline, with the number falling from almost 10,000 in 1996-97 to under 7,000 in 2006-07. This trend runs counter to patterns of alcohol consumption in Scotland and may be related to changes in charging practices. For example, Lothian and Borders police reported that their force no longer routinely charge people with being drunk and incapable.

3.38 Drunkenness offences include:

- Drunk and incapable and habitual drunkenness
- Drunk in charge of a child
- Drunk and attempting to enter licensed premises
- Drunk or drinking in unlicensed premises
- Disorderly on licensed premises or refusing to quit and
- Drunk in or attempting to enter designated sports ground.

3.39 In 2006-07, the number of drunkenness offences varied from nearly 2,000 in Glasgow to 8 in the Orkney Islands and East Lothian.

3.40 To ascertain the impact of drunk and incapable people on the police, all police forces in Scotland (including the British Transport Police) were requested, via the Association of Chief Police Officers in Scotland (ACPOS), to provide anonymised data on the number of charges they recorded as “drunk and incapable” in the period 1 April 2007 – 31 March 2008. A breakdown of these charges was requested by gender, age, ethnicity and whether the charged person was homeless (of no fixed abode), along with data on the date and time of the offence. Unique person-specific ID codes for each charge enabled us to calculate the number of repeat offenders – i.e., the individuals charged with being drunk and incapable on more than one occasion in the year.

3.41 According to this data, in 2007-08, Scottish police forces made 5,502 charges to individuals for being drunk and incapable.\(^\text{18}\) (See Table 3.1.) This equates to an average of 106 charges per week across Scotland.

3.42 It should be noted that the majority of people who are charged with the offence of being drunk and incapable would be charged with that offence only. However, the police handle a very large number of people who are under the influence of alcohol at the time of arrest. An analysis of 5,000 arrests by one Glasgow police station in 2006-07, showed that 60% were under the influence of alcohol and/or drugs at the time of arrest. Of those detained for violence, two-thirds were under the influence of alcohol.\(^\text{19}\) People who are arrested by the police and charged with other offences would generally have to be kept in custody and therefore would be unlikely to be suitable for other types of services such as, for example, a designated place.

### The characteristics of drunk and incapable offenders

3.43 As Table 3.1 shows, the greatest number of charges for being drunk and incapable was in the Strathclyde Police area, with 3,334 charges in 2007-08. Within the Strathclyde Police area, Glasgow City, North and South Lanarkshire and Renfrewshire had the highest number of charges. The police force with next highest number of charges was Northern Constabulary with 750. All other force areas had fewer than 350 and the smallest number of charges was in Lothian & Borders with 103.

3.44 As mentioned above, forces vary in their policies for dealing with people who are drunk and incapable.\(^\text{20}\) There are five different ways that Scottish police forces deal with drunk and incapable people:

- Firstly, it is important to note that, most forces in Scotland charge most people who are drunk and incapable in public with that offence.

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\(^{18}\) Note that this is not the same as charging 5,502 individuals, since, as will be seen below, the same individual may have been charged on more than one occasion during this period.

\(^{19}\) Unpublished data from Strathclyde Police, cited in the Scottish Government’s alcohol strategy discussion paper, *Changing Scotland’s relationship with alcohol*, see page 52.

\(^{20}\) All forces in Scotland, including the British Transport police, provided information on their charging policies.
Table 3.1: Charges for being drunk and incapable under section 50(1) of the Civic Government (Scotland) Act 1982, by police force and local authority, April 2007 – March 2008

<table>
<thead>
<tr>
<th>Police force where offence was committed</th>
<th>Local authority where offence was committed</th>
<th>Number of drunk and incapable charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central*</td>
<td>Clackmannanshire</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Falkirk</td>
<td>82</td>
</tr>
<tr>
<td></td>
<td>Stirling</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>170</strong>*</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>Dumfries &amp; Galloway</td>
<td>129</td>
</tr>
<tr>
<td>Fife</td>
<td>Fife</td>
<td>369</td>
</tr>
<tr>
<td>Grampian</td>
<td>Aberdeen City</td>
<td>83</td>
</tr>
<tr>
<td></td>
<td>Aberdeenshire</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Moray</td>
<td>76</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>199</strong></td>
</tr>
<tr>
<td>Lothian &amp; Borders</td>
<td>East Lothian</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Edinburgh City</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td>Midlothian</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Scottish Borders</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>West Lothian</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>103</strong></td>
</tr>
<tr>
<td>Northern</td>
<td>Highland</td>
<td>616</td>
</tr>
<tr>
<td></td>
<td>Orkney</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Shetland</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>Western Isles</td>
<td>82</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>750</strong></td>
</tr>
<tr>
<td>Strathclyde</td>
<td>Argyll and Bute</td>
<td>139</td>
</tr>
<tr>
<td></td>
<td>East Ayrshire</td>
<td>73</td>
</tr>
<tr>
<td></td>
<td>East Dunbartonshire</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>East Renfrewshire</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Glasgow City</td>
<td>1,413</td>
</tr>
<tr>
<td></td>
<td>Inverclyde</td>
<td>182</td>
</tr>
<tr>
<td></td>
<td>North Ayrshire</td>
<td>166</td>
</tr>
<tr>
<td></td>
<td>North Lanarkshire</td>
<td>433</td>
</tr>
<tr>
<td></td>
<td>Renfrewshire</td>
<td>215</td>
</tr>
<tr>
<td></td>
<td>South Ayrshire</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>South Lanarkshire</td>
<td>323</td>
</tr>
<tr>
<td></td>
<td>West Dunbartonshire</td>
<td>247</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>3,334</strong></td>
</tr>
<tr>
<td>Tayside</td>
<td>Angus</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Dundee City</td>
<td>307</td>
</tr>
<tr>
<td></td>
<td>Perth &amp; Kinross</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>348</strong></td>
</tr>
<tr>
<td>British Transport Police</td>
<td>Scotland</td>
<td>109</td>
</tr>
</tbody>
</table>

| Scotland | 5,502 |

* The break-down of charges by local authority in the Central Police Force Area does not total 170. Local authority was not recorded for nine charges.
• Three police forces (Dumfries and Galloway, Grampian and Tayside) report that a fixed penalty notice or a warning letter may be issued to a minority of people who are drunk and incapable (for example, first time offenders in Tayside). However, all three forces said that this would, nevertheless, be recorded as a charge.

• Two forces (Grampian and Northern) have access to a designated place where they can take drunk and incapable people, although there are limited spaces, so this only applies to a minority of offenders. Those people who are taken to a designated place are not charged with being drunk and incapable. It is worth noting, however, that if space is not available, people identified as drunk and incapable would be charged. Both Grampian and Northern police forces cover large rural areas, and in practice, only the police in the area immediately surrounding the designated places are likely to access them on a regular basis.

• Lothian and Borders police force is unique in Scotland in making a policy decision not to routinely charge people with the offence of being drunk and incapable. Instead, if an intoxicated person is assessed as not needing to attend hospital or to be kept in custody (for example because of another offence), he/she would be taken home or placed in the care of a responsible person. This means that the figures shown for Lothian & Borders Police in Table 3.1 under-estimate the actual number of drunk and incapable people the force deals with.

• Fife Constabulary has a joint protocol in place with the Scottish Ambulance Service which means that, if a person is reported being drunk and incapable, the police request an ambulance to attend to assess the individual. Depending on the individual’s condition, the ambulance staff may decide either to take the person to hospital or leave him/her where they are. There is no formal policy on charging and each case is decided on an individual basis. Some people may be charged with being drunk and incapable and some may be issued with an anti-social behaviour fixed penalty notice. Fife Constabulary were unable to estimate the proportion of people who would be charged with being drunk and incapable.

3.45 As Table 3.1 shows, the local authority areas with the highest numbers of charged drunk and incapable offences in 2007-08 were Glasgow City with 1,412, followed by Highland (616), North Lanarkshire (433) and Fife (369). On average, these figures represent one or more charges per day.

3.46 Most other local authority areas had fewer than 250 charges in this period. The lowest numbers of charges were recorded in the Lothian & Borders police area: East Lothian (6), Midlothian (6), Scottish Borders (8) and West Lothian (8); and in Orkney (8), Perth & Kinross (13) and Clackmannanshire (16).

3.47 In all local authority areas the vast majority of individuals charged with being drunk and incapable were white and male. On average, they were aged between 33 and 47. The youngest persons charged in 2007-08 were aged 12 (in Dundee, Glasgow and by the British Transport Police). The oldest person
charged was aged 90 (in North Lanarkshire). (For details, see Table B.4 in Appendix B.)

3.48 Among those charged with the offence of being drunk and incapable, the number who were of no fixed abode was small across all areas. In addition, people were generally charged in the same local authority in which they were resident. The exception was East Renfrewshire, where only about a third (8 out of 22) charges were made to people who lived in East Renfrewshire. All other charges made in East Renfrewshire were made to people who lived outside the area. (See again Table B.4 in Appendix B for details.)

3.49 Most drunk and incapable offences occurred at night and at weekends (data not shown).

Repeat offenders

3.50 Most forces were able to supply identification codes so that the number of repeat offenders during the year could be calculated for each local authority. However, these codes were not available from Dumfries & Galloway or Northern Constabulary forces. In areas for which data was available, the number of repeat offenders ranged from none in East Renfrewshire and Perth & Kinross to 127 in Glasgow. (For details, see Table B.5 in Appendix B.)

3.51 We calculated the number and percentage of charges in the year 2007-08 for which repeat offenders were responsible. In most areas, the proportion of offences for which repeat offenders were charged was more than 25% — in other words, a relatively small number of people are responsible for a quarter or more of drunk and incapable charges in those areas. Across all local authority areas, the level of repeat offending ranged from 11% in East Dunbartonshire by three repeat offenders to 50% in Moray by nine repeat offenders. (See again, Table B.5 in Appendix B.)

Estimating the demand for other services based on police data

3.52 The data received from the police indicate that there are at least 5,502 charges made each year to individuals for being drunk and incapable, or 106 charges per week. It is not clear from the data whether all of these individuals were taken into custody.

3.53 The average cost of holding an arrestee overnight in police custody has been estimated as £385 per night. Therefore, if all 5,502 individuals charged with the offence of being drunk and incapable were held in police cells overnight, then the cost of this could be estimated to be around £2.12m per year across Scotland.

21 Several local authorities in Lothian & Borders Police area also had no repeat offenders but this is because of the small number of charges overall in Lothian & Borders.
3.54 It is likely that these figures — 5,502 charges and £2.12m per year — underestimate the true size of the problem, as they do not include drunk and incapable people with whom the police have contact, but who are not charged. As mentioned above, for example, Lothian & Borders police do not routinely charge people with the offence of being drunk and incapable. Rather they seek to take the individual home, or place them into the care of a responsible individual. Clearly, police time is required to do this, and it could be argued that that time could be better used on policing, rather than providing a taxi service. If it is assumed that Lothian & Borders police dealt with a third as many drunk and incapable people as Strathclyde Police (since the Lothian & Borders Police area has just over one-third the population of the Strathclyde Police area), this would bring the total number of drunk and incapable people dealt with by the police across Scotland to around 6,600, or 127 people per week.

3.55 Local authorities with the biggest apparent problem are Glasgow City, Highland, North Lanarkshire, Fife, South Lanarkshire and Dundee City. However, it can be argued, and it has been argued in a report from HM Inspectorate of Constabulary for Scotland, that every single individual who is arrested by the police for the offence of being drunk and incapable (who has committed no other offence) is a vulnerable individual whose needs should be addressed by a service other than the police.\(^{23}\) In addition, suitable care needs to be provided within police custody for the large number of intoxicated arrestees who may not be eligible for an alternative service because of the other offences they have committed.

**Data from other services**

3.56 In addition to the national data presented above, we also gathered data from other services that aim to address the needs of drunk and incapable people.

**Use of designated places — Beechwood House and Albyn House**

3.57 Beechwood House in Inverness and Albyn House in Aberdeen both provide four-bed designated place facilities for drunk and incapable people.

3.58 Beechwood House currently receives around 1,000 referrals a year.\(^{24}\) Managers estimate that there has been a steady increase each year over the 19-year period of its operation. Figures provided by the service for the period April 2007 to March 2008 showed that there were 1,100 referrals. Of these, 199 (18.1%) were refused. The greatest number of referrals came from the police (n=398, 36.2%) and the NHS (hospital (n=239, 21.7%); GPs / CPNs / NHS24 (n=168, 15.3%)).

3.59 Of these 1,100 referrals:

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\(^{24}\) Note that this figure relates to referrals, not clients. Some individuals may have been referred more than once.
• The male / female ratio was around 6:1
• The majority of referrals were aged between 35 – 64
• Around 40% were repeat referrals
• 425 (36.8%) were single, 204 (18.5%) were divorced or widowed, and 86 (7.8%) were married
• 146 (13.3%) had no fixed abode
• 180 (16.4%) had a diagnosed disability and 170 (15.5%) had mental health problems.

3.60 A report carried out for Northern Constabulary on Beechwood House activity during the 18-month period (April 2006 – September 2007) indicated that the service received an average of 79 referrals per month. The largest number of referrals were received between April and September. The majority of weekend referrals (Friday to Sunday) were from the police, while the majority of referrals during the week (Mondays to Fridays) were from other agencies.

3.61 In Aberdeen, a report on the designated place at Albyn House produced by Aberdeen City Council showed that there were 686 admissions by 397 users in 2007, compared to 545 admissions of 292 users in 2006, and 653 admissions by 282 users in 2002.

3.62 Service users at Albyn House were reported to fall into two main groups. The first group used the service only once (range between 32-45% of bed usage). The second group were alcohol-dependent people who accounted for 19-35% of bed usage. These individuals have used the facility at least eleven times each, but in many cases their level of use will have been much higher.

3.63 The data from Albyn House showed that the peak period for admissions is the summer. The busiest month is August and there were a number of occasions when there were four or more admissions in a day. However, there is no general trend or pattern in the data to show that any particular day of the week is busier than another. The average (mean) occupancy for the entire month of August was 2.5 users / day in 2006 and 2.6 users / day in 2007.

3.64 In 2007, the busiest days of the week for the Albyn House designated place were Thursdays (an average of 2.8 to 3 clients) and Saturdays (an average of 3 to 3.8). There were 64 days where the designated place had no clients and 20 days where there were five or more users. Interviews with staff indicate that the average length of client stay is approximately eight hours.

3.65 The largest proportion of Albyn House clients range in age from 40 – 60 years. Male clients outnumbered females by 5:1, although the service manager suggested that the number of female clients was increasing.

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25 Activity analysis on Beechwood House Designated Place by Northern Constabulary Criminal Intelligence Unit (November 2007).
26 The Designated Place at Albyn House and the Night Time Economy (unpublished 2008).
27 As there are only four beds in Albyn House, this is probably because individual clients stayed for a relatively short period of time on these days.
3.66 As with Beechwood House, the greatest proportion of referrals to Albyn House were made by the police.

3.67 The service manager indicated that the proportion of homeless people attending the service had fallen over time. However, the data shows that, while the largest proportion of discharges (around 45-55%) return home, there is still a percentage (22% in 2002, 17% in 2007) who have no fixed abode. These are figures for the number of discharges, not clients so there may be over counting but the Aberdeen report suggests that it is generally accepted that people of no fixed abode use the designated place more than others.

3.68 There has been an increase of approximately 16% between 2002 and 2007 in the percentage of low level users (three times or less). The service manager estimated that approximately two-thirds of clients in recent years have been “one-offs”. He also described a group of cyclical users who present frequently during a time of crisis and then do not re-appear, or at least not for a long time. In addition, he suggested that the increase in new referrals in 2007 was due to an increase in binge drinking.

3.69 It is perhaps worth noting that both Beechwood House and Albyn House had large numbers of clients who were repeat attenders — much larger than the police data on repeat charges would suggest. This may mean that certain individuals are known by the police and are taken to the designated places as a matter of course, rather than arrested and charged for being drunk and incapable.

Temporary services in Glasgow, Aberdeen and Edinburgh

3.70 Some areas have put in place temporary services at times when greater numbers of people present to emergency services with injuries incurred on the streets, e.g., the Festive period over Christmas and New Year. Such services may not be exclusively for drunk and incapable people, but this group forms a significant proportion of the clients / patients. We looked at triage and treatment services in Glasgow, Aberdeen and Edinburgh, which all had the aim of reducing the numbers of presentations at emergency departments.

3.71 The Glasgow Mobile Medical Resource and supporting first-aid post ran over four weekends from Friday, 14 December to Sunday, 6 January 2008. During these weekends, the service dealt with 96 people. Males comprised 70% of the clients. The youngest person treated was 16 years old and the oldest was 60. Overall, the average age of clients was 29 years. Alcohol had been consumed by 81 (84%) of people using the service and five people were treated specifically for intoxication.

3.72 Forty-three people (44.8%) were treated as a result of an assault and 18 (18.8%) were treated as a result of an accident. The remaining 35 (36.5%) had symptoms related to illness. Only 25 people (26%) required hospital treatment while 60 (62.5%) were treated on-site. Eleven other individuals (11.5%) were assessed but required no treatment.
3.73 In 2007, a triage facility was piloted in Aberdeen in response to the large numbers of people in the city centre at weekends who sustain injuries requiring medical attention while under the influence of alcohol. The aim was to reduce the impact on the emergency department and ambulance service.

3.74 The service operated over one weekend in June and two weekends in December 2007 (but not the weekend preceding Christmas). It dealt with 22 patients, of whom: nine were admitted to Albyn House, four were taken to the emergency department and nine were assessed and discharged. A separate triage facility at the Hogmanay Party in 2007/8 treated 50 casualties in a 3.5 hour period with only seven being taken to the emergency department. However, it was part of a comprehensive strategy to manage the Hogmanay event with other services or facilities also available.

3.75 The Edinburgh Hogmanay Sleep-Over Facility is a temporary service, staffed by medical personnel and first aiders and based in a city-centre church hall. The clients are drink-related casualties transferred from the four additional first-aid posts in operation along Princes Street. Twenty people were admitted on Hogmanay 2007/8.

3.76 Further details of these services are given in Chapter 5.

**What do we know from interviews?**

3.77 So far, this chapter has focused on identifying the number of drunk and incapable people who could potentially be diverted from police custody and whose needs could be met by a service other than a hospital emergency department or in-patient service.

3.78 However, there are other, more qualitative factors, which are relevant to any discussion about possible alternative services for drunk and incapable people. In our interviews with service managers and stakeholders, we found a high level of agreement about the factors that contribute to a need for services.

3.79 First, people who are intoxicated to the point of not being able to look after themselves are vulnerable. They are prone to injury through accident or assault and, if they become comatose, they may choke on their vomit. They may also suffer hypothermia if they are out at night in light clothing. Interviewees felt strongly that they need to be kept safe while they sober up and to have their physical condition monitored.

3.80 Second, people who become drunk and incapable are not a homogeneous group. Our interviews suggest that managers and stakeholders perceive there to be, broadly, three groups:

- “One-offs” who have drunk to excess on a night out, who attend the service once, and never appear again
- Binge drinkers who are not alcohol dependent but who will quite regularly consume large amounts of alcohol on weekends or special occasions, and who may present to services more than once
• Chronic, or recidivist drinkers.

3.81 Interviewees suggested that people in the first two groups usually had jobs and homes, but that people in the third category were more often unemployed and could be homeless or staying in hostels. Interviewees from the Scottish Ambulance Service, in particular, identified young binge drinkers (and were particularly concerned about the vulnerability of young women) and chronic drinkers as key groups for their service.

3.82 For all three groups their immediate needs may be the same — to be kept safe and monitored. However, people who have chronic drink problems may require closer attention because they are in poorer physical condition or may exhibit symptoms of withdrawal including the risk of seizures. They ordinarily will also have more complex social needs in addition to their alcohol dependency. In contrast, interviewees suggested that young people’s associated needs were more related to needs for advice or education.

3.83 In most areas of Scotland, the current arrangements whereby drunk and incapable people are taken to police cells or hospital emergency departments are regarded as unsatisfactory:

• By the police: because of the demand on time and resources and pressure on cell blocks, especially at weekends, and concerns about the inadequacy of police custody suites to meet their care needs. It was also suggested that people arrested by the police are less likely to respond to offers of help because they see a police cell as a hostile environment.

• By emergency department staff: because of the demand on time and resources, sometimes including the use of beds, and the disruption and distress to other patients which can be caused by intoxicated patients.

• By the Scottish Ambulance Service: because calls to attend drunk and incapable people divert vehicles from calls to other patients and have an impact on achievement of Ambulance Service standards.28

• By ADATs and other stakeholders: because of the pressure on emergency services and the limited opportunities to address the longer term needs of the individuals.

• By service users: who reported experiences of inadequate care in police cells.

3.84 Interviewees suggested that one of the main difficulties in meeting the needs of drunk and incapable people was that no one agency felt responsible for this group. This was seen to have an impact on funding. The most common view was that health services should have a greater role in establishing and running of services. Stakeholders felt that, while acute services may provide

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28 Standards agreed with Scottish Government (very similar to UK standards), based on initial call triage and prioritisation within control centres: Category A (life threatening) – 75% in 8 minutes; Category B (emergency) – 75% in 14 mins (urban); 18 mins (rural); and Category C – Time dependant on clinical need / response may not be by SAS.
Immediate care, there was also a need for community health services to take a more proactive approach.

3.85 There is also a difference between the nature and scale of demand in city centres and rural areas. In city centres such as Edinburgh, Glasgow and Aberdeen, there is a strong night time economy which brings an influx of people into the city for nights out, hen and stag weekends and short breaks. In some cases, people come from long distances. The Festive Period around Christmas / New Year is an especially busy time with the additional pressure of office parties. The number of people, therefore, who may require to be removed from the streets for their own safety may be quite considerable. In many cases, it is not possible to take people home as they do not live locally.

3.86 In Edinburgh, the ambulance service experiences difficulties in supplying enough vehicles to pick up people from the (at least four) different locations in the city where there is a concentration of people drinking in licensed premises.

3.87 Interviewees described different problems in rural areas. In rural areas, the scale of the problem is smaller but people are more scattered. It takes more time to transport people to hospital or to police cells. It was reported that, while there is a pattern of drinking at home in some communities (e.g., the islands), there are other areas where there is a recognised problem of people being picked up in the streets (e.g., Fort William and parts of Borders). In the Borders there are also annual events like the Riding of the Marches which can lead to drunkenness among large numbers of people.

3.88 There are also problems presented by young drinkers. Two examples were highlighted in our survey of ADATs. An audit of emergency department presentations in Dumfries & Galloway showed no clear process for dealing with intoxicated young people, a lack of clarity about treatment and no follow-up action for the majority. The need was mainly in the areas of highest deprivation. In Dundee, young people are frequently picked up by the police in a drunk and incapable state, mainly on Friday and Saturday night in the city centre. The majority are “one-offs” or occasional binge drinkers who put themselves at risk and disrupt local residents.

3.89 All stakeholders felt that some form of intervention or further support was needed to reduce drinking levels and prevent further incidents. In particular, interviewees felt strongly that, in order to meet the needs of chronic drinkers, services should have better links to medical or social interventions on a longer term basis. For this group, there may also be a need to address accommodation issues.

Unmet need

3.90 In it perhaps worth mentioning, as an aside, that our interviews not only identified needs for services for drunk and incapable people, but also some unmet needs in relation to other (related) populations. In particular, stakeholders expressed a need for services for:
• People who have co-existing alcohol and mental health problems
• People who have alcohol acquired brain injury and whose cognitive difficulties mean that they are very likely to start drinking again as soon as they are discharged from support services
• Underage drinkers on the streets.
## 4 SERVICES FOR DRUNK AND INCAPABLE PEOPLE AROUND THE WORLD

### Summary of main points

**Sobering-up services**
- A review of the international literature identified sobering-up facilities in Australia and North America. There was evidence from Australia of these services providing clients with physical and emotional care, support and brief interventions, and they were perceived to be safer and a better use of resources than holding intoxicated people in police custody.
- There is no single best-practice model for these services. However, it is important that there are clear protocols and procedures which are agreed with the police and local health services. Staff should be trained in first-aid, and there should be good links with rehabilitation, housing and social care services.
- Services should be developed in response to local needs and should be flexible in responding to changing needs. Key stakeholders (including the police, local health authorities, service providers and the local community) should be involved in the planning and decision-making process involved in setting up the service.

**Transportation services**
- There was evidence of free transportation services operating in conjunction with sobering-up services in both Australia and North America. In some cases, these services may patrol city streets to pick up intoxicated people, and in other cases, they may be directed to intoxicated people by the police.

**Providing medical support in police custody suites**
- Studies have shown that alcohol can be a factor in a substantial proportion of arrests in the UK. A distinction can be made between alcohol-specific offences (such as drunkenness or drink driving) and alcohol-related offences (where the detainee was drunk or had been drinking prior to arrest for another offence). Alcohol-related detainees spent significantly longer in custody than other detainees while alcohol-specific detainees spent less time in custody, since most were held until they were sober, then released.
- There were a small literature on the role of the forensic medical examiner (FME) and custody nurses in providing care for people detained in custody. A large part of the job of the FME and custody nurse involves assessing the fitness of people to be held in custody.

**Mobile triage services / SOS buses**
- A model of service which is being used increasingly to meet the needs of drunk and incapable people in the UK, involves the use of a bus or other mobile unit. These so-called SOS buses provide immediate assistance to people who may be intoxicated, distressed or have minor injuries. They offer first-aid (including, in some cases, social and emotional first-aid), and a place of safety for people until they are able to be taken home by a family member, friend or taxi. These services are largely based in busy, city-centre locations. Most operate only at the weekends or during special events.
4.1 This chapter presents a summary of the main findings of an international review of the literature on services that manage the care needs of drunk and incapable people. A full report of this review has been published separately.\(^29\) The purpose of the review was: a) to describe what these services look like in countries outside of Scotland; and b) to identify good practice in providing these services. Chapter 5 will discuss our findings in relation to services in Scotland.

4.2 Most of the literature identified in this review was on the subject of sobering-up services, and the best of this literature came from Australia. A few reports were also identified from North America (USA and Canada), but the quality of this material was generally poorer.

4.3 In addition to the literature on sobering-up services, this chapter also summarises findings from a smaller literature on other types of interventions. These include:

- Free transportation services
- The provision of medical care within police custody suites (for example, through custody nurses)
- Temporary places of safety / mobile services / SOS bus services

### Sobering-up services

#### The Australian context

4.4 Australia has a well-established system of sobering-up services across the country. These were first developed in the 1980s as a result of the decriminalisation of public drunkenness, which took place at different times in different states, and which led to the creation of “proclaimed places” – the equivalent of “designated places” in Scotland. There was further expansion in the number of services following publication in 1991 of the findings of the Royal Commission into Aboriginal Deaths in Custody.\(^30\)

4.5 The Royal Commission was set up to investigate the disproportionate number of deaths in custody of Aboriginal and Torres Strait Islander peoples. The Commission found that many of these deaths were associated with arrests for public drunkenness. A number of wide-ranging recommendations were made, including that:

- *In jurisdictions where drunkenness has not been decriminalised, governments should legislate to abolish the offence of public drunkenness* (Recommendation 79)

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\(^{29}\) Griesbach et al, 2009.

\(^{30}\) Royal Commission into Aboriginal Deaths in Custody, 1991.
• Adequately-funded programmes should establish and maintain non-custodial facilities for the care and treatment of intoxicated persons (Recommendation 80)

• There should be a statutory duty upon the police to consider and utilise alternatives to the detention of intoxicated persons in police cells. Alternatives may include taking the intoxicated person home or to a facility established for the care of intoxicated persons (Recommendation 81).

4.6 In general, sobering-up services in Australia have the aim of harm reduction. The additional aim of these services (particularly in light of the findings of the Royal Commission) is to divert intoxicated people from police custody. It should be noted that most sobering-up services in Australia accept people who are intoxicated with either alcohol or drugs.

4.7 Sobering-up facilities in Australia are not detoxification services, nor do they provide long-term rehabilitation, although many are linked to treatment and rehabilitation services in their areas. Their role is to provide an alternative to police custody, to reduce alcohol- or drug-related harm and to offer shelter, food and protection in a safe environment for a limited time. They also provide opportunities for brief interventions by drug and alcohol workers and referrals for further assistance in a manner which is respectful and humane.

The North American context

4.8 As in Australia, sobering centres began to be developed in the United States in the 1980s in response to the decriminalisation of public drunkenness in many states. More recently, the impetus for establishing these services has been to reduce pressure on the police. Moreover, unlike in Australia, the need to reduce pressure on hospital emergency departments has also been a big driver. In the American literature, the argument in favour of establishing sobering centres was often presented in economic terms – i.e., it was a poor use of financial resources for the police, or emergency departments, to have to deal with people who simply needed a place to sleep it off.

4.9 It was less common for reports to identify a public health or humanitarian impetus for these services, although one proposal for a “emergency service for substance abuse” from the state of Vermont was an exception.

32 A comment was made in one report that the term “sobering-up centre” suggests that these facilities deal only with people intoxicated with alcohol.
33 Brady et al, 2006.
34 The number of states which have decriminalised public drunkenness is unknown.
35 Ericksen, 2005; Chesky, 2000; Rhodes, 2004; Bula, 2008.
Description of the services

4.10 In Australia, sobering-up services have developed in different ways in different states, and even within states, there is considerable variation between services in relation to opening hours, client population, admission criteria and service management. However, services generally have the following common features:

- Police (or community-based night patrols) deliver clients to the centre
- Clients are showered
- Clients belongings are removed and recorded
- Clothing is laundered
- Client is rehydrated with a cordial or other non-alcoholic drink
- Client is given a bed and left to ‘sleep it off’
- Client is observed at regular intervals by staff trained in first aid and in the identification of withdrawal symptoms
- Client may be given a Vitamin B tablet
- Where appropriate, the client is referred to treatment services
- Clients may leave at any time and may not be detained against their will.

4.11 Many of the differences between services appear to have developed in direct response to local needs. In addition, according to one report, each centre is run to a large extent according to the philosophical, religious or cultural beliefs of the organisation that manages it.

4.12 Compared to Australian sobering-up services, the facilities available in North American sobering centres generally appeared to be very basic. In some areas, services were described as “little more than mats on the floor”. In another area, people were “left to sleep it off on a concrete floor”. Yet another service was provided in a large marquee-style tent (40 ft²), with sleeping facilities provided on camp beds.

4.13 Although many American services seemed to offer spartan facilities, there were also services which appeared to be more similar in nature to those offered in Australia – where the client was offered food and a change of clothing in addition to a bed for the night. As in Australia, differences between services in North America may be partly due to differences in philosophies between agencies. However it is possible that differences in state policies / politics may also play an significant role in the way services are delivered in North America.

37 High levels of alcohol consumption result in Vitamin B deficiencies in the body.
40 Beaven, 2008; Behavioral Health Research & Services, 2004a.
41 See http://www.fresnorescuemission.org/safearea.html.
42 Chesky, 2000; King County Department of Health and Human Services, undated.
**Opening hours and length of stay**

4.14 As mentioned above, opening hours in Australian sobering-up facilities vary, and may range from a couple of nights a week for a couple of hours each night, to full 24/7 provision. One report made the point that when these services are closed, there is no alternative but to place people who are drunk and incapable in police cells.\(^{43}\)

4.15 The literature from North America suggested that sobering centres are often available 24 hours a day, 7 days a week. However, the average length of client stay is short, i.e., 4-6 hours (just until they are sober).\(^{44}\)

**Staffing**

4.16 There was little information about staff training and qualifications in Australian sobering-up services, although what information there was suggested that qualifications and experience vary.

4.17 One service was described as having a multidisciplinary staff team with experience and/or training in drug and alcohol work, mental health, homelessness, crisis intervention, counselling, risk assessment and care management. All staff members in this service also had qualifications in first-aid, and two were qualified registered nurses. In addition, as part of their work, staff undertook training in motivational interviewing, conducting pat searches (frisking), data collection and reporting, drugs and alcohol awareness, mental health awareness, suicide intervention and personal safety.\(^{45}\)

4.18 While staff in some services appeared to be highly trained, staff in others may be less so. Indeed, one review identified a specific need for alcohol and drug training for staff in sobering-up services in Tasmania.\(^{46}\)

4.19 An important part of the role of a sobering centre is to assess whether a client is in need of more specialised medical attention. Staff therefore require training to recognise the common medical problems associated with alcohol and drug dependency, and must be able to provide emergency first-aid when required. In North America, it appeared to be standard for sobering-up services to employ trained (and licensed) Emergency Medical Technicians (roughly equivalent to a Paramedic in the UK).

4.20 In addition to training, other staff qualities are also likely to be important. One report indicated that a caring environment with non-threatening and non-

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\(^{44}\) Santa Barbara County Grand Jury, 2001; Beaven, 2008; Alameda County Behavioral Healthcare Services, 2008a.

\(^{45}\) Allen-Kelly et al, 2006.

\(^{46}\) Healthcare Management Advisors Pty Ltd, 2008.
judgemental staff was one of the keys to success in providing a sobering-up service.47

4.21 It is perhaps worth mentioning that gender was also mentioned as an issue in the staffing of sobering-up shelters in Australia. Because of the requirement to provide intimate personal care to clients who are intoxicated and vulnerable, it was seen to be important to provide both male and female staff where a shelter accepted both male and female clients.48

**Admission, exit and safety procedures**

4.22 In Australia, clients were generally brought to the service by the police, or by community-based night patrols (described later in this chapter). In some areas, the night patrol works with the police to transport intoxicated persons from the police station.49 Some facilities also received referrals from hospital emergency departments (as a place to discharge intoxicated people following treatment), and some accepted self-referrals.50

4.23 In North America, clients are generally delivered to the facility by the police or by a specially funded transportation service. While some American sobering centres also accepted self-referrals,51 others did not.52

4.24 Admission procedures appeared to be similar in Australian and North American services, although this is largely inferred from the findings of an audit of a service in Washington State which was initiated at the request of the local government authority following one service’s third fatality in a 12-month period. The audit report highlighted a number of failings in the admission and client monitoring procedures used in the facility. The findings suggested that very strict protocols for client admission are generally in place in such facilities, and that these include protocols for deciding when a client should be referred to a qualified medical provider.53

4.25 In Australia, some services only accept intoxicated people who are conscious and able to walk unassisted; others appear to accept people who are more severely intoxicated.54 In both Australia and North America, the literature suggests that clients are ordinarily breathalysed upon entry to the facility, and other assessments may also be undertaken. If the client wishes, a responsible person may be contacted to come collect them.

4.26 In general, if a client is seen as potentially violent or aggressive, they are not usually admitted to the sobering-up shelter; they are instead held in police

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50 Brady et al, 2006.
51 Behavioral Health Research & Services, 2005a.
52 Alameda County Behavioral Healthcare Services, 2008a.
54 Allen-Kelly et al, 2006; Brady et al, 2006.
cells. Having said that, there were some examples in the Australian literature where a sobering-up shelter had a security room in which to place aggressive persons.  

4.27 During their stay in the service, clients are regularly monitored. This may be done by entering the client’s room, or by looking through a window into the room. Some services also had video surveillance systems. In Australia, regulations for the monitoring of clients in sobering shelters are set out in legislation.

4.28 Similar procedures exist in North America, and one of the criticisms voiced in the audit report in relation to the service in Washington (mentioned above) was that client monitoring practices had deteriorated since the facility opened.

4.29 Exit procedures involve returning the client’s clothing and property, updating records and, in some cases, arranging safe transport for clients to their destination. In Australia, there was evidence of services offering clients a light breakfast.

4.30 The period prior to discharge is also when staff work with the client to establish what other needs they may have and how the service can assist them with information or referral to other services. Sobering-up services may also attempt to provide brief interventions – where the client is given information about the effects of drinking, and possible alternative behaviours to avoid becoming severely intoxicated in the future.

**Client profile**

4.31 In Australia, indigenous Australians comprise the majority of service users. Clients are mostly male, although these services also available for women. There was evidence of some female-only services as well. The age structure of clients varies widely from one centre to another. There were also a small number of shelters provided exclusively for young people.

4.32 In both Australia and North America, the literature suggests that sobering-up centres are largely used by people with chronic alcohol problems, many of whom are also homeless. In Australia, this can result in frequent use of the service by the same individuals. There did not appear to be any restrictions

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56 Australian Capital Territory, *Care and Protection of Intoxicated Persons Standard 2004*. The *Standard* also sets out requirements in relation to record-keeping and staff training and qualifications.
60 Allen-Kelly & McArthur, 2005.
against this.\textsuperscript{61} The evidence from Australia suggests that binge drinkers have generally comprised a small minority of clients.\textsuperscript{62}

4.33 In North America, sobering-up services have traditionally been targeted towards people who are alcohol- or drug-dependent and homeless. However, this has begun to change. More recently, admissions to sobering centres have begun to include a greater proportion of people who might be described as “social drinkers”.\textsuperscript{63} This demographic change has resulted in services needing to change the way they do things.

\textbf{Links to other services}

4.34 Although sobering-up shelters in Australia were initially conceived as harm reduction interventions, a number of reports expressed dissatisfaction with what had, over the years, become a ‘band-aid’ — or ‘revolving door’ — approach to dealing with public drunkenness. Many of the shelters were being used night after night by the same chronically intoxicated homeless people whose real needs could not be met in the context of a sobering-up shelter. Several Australian states had recently taken steps to better integrate sobering-up services with homeless services and drug and alcohol services. However, the extent to which this has happened seems to have varied from one state to another.\textsuperscript{64}

4.35 American sobering centres were often co-located with longer-term detoxification facilities to allow easy referral for clients who were interested. Several services were also located near hospitals or medical centres.\textsuperscript{65}

\textbf{Rural issues}

4.36 All the information available on North American sobering-up services relates to services in urban areas. It is not known to what extent these services are available in rural areas in North America.

4.37 In Australia, sobering-up shelters are as likely to be in rural areas as urban areas. For example, in Western Australia, 11 of the state’s 14 facilities are in rural areas.\textsuperscript{66} However, the point was made in one report that, “it is much more difficult to deal with intoxicated people in rural areas”, largely because of the lack of services in rural areas, in general. This lack of services relates not only to services (such as the police, hospital or sobering centre) which are ordinarily the first to identify a problem of public drunkenness, but it also relates to services that people can be referred onto for help – such as

\textsuperscript{61} Brady \textit{et al}, 2006; Parliament of Victoria, 2000.

\textsuperscript{62} Parliament of Victoria, 2000.

\textsuperscript{63} Beaven, 2008.


\textsuperscript{65} Beaven, 2008; Alameda County Behavioral Healthcare Services, 2008a; Bula 2008; Ericksen, 2005.

\textsuperscript{66} Government of Western Australia, 2007.
detoxification, treatment or support services. The police in rural and remote areas often have no choice but to hold intoxicated people in police cells.\textsuperscript{67}

4.38 The provision of free transportation services with sobering-up services may be particularly important in rural areas. The evaluation of one Australian rural service showed that the facility worked together with a mobile assistance patrol, which provided a free bus service.\textsuperscript{68}

**Outcomes**

4.39 In considering the outcomes of sobering-up services, it is important to be clear about the two main aims of these services. These are: (1) to give people a safe place to sober up from the effects of alcohol or drugs; and (2) to divert people from police custody. Based on these two aims, evaluation evidence from Australia indicates that sobering-up services are largely effective.

4.40 Services were reported to provide clients with physical and emotional care, support and brief interventions, and they were perceived to be much safer than holding intoxicated individuals in police custody.\textsuperscript{69}

4.41 In Australia, the provision of sobering-up centres was reported to have a dramatic impact on the number of intoxicated individuals held in police custody. One report from Western Australia showed that, between 1992 – 2005, the number of police detentions of intoxicated persons across the state had declined by a massive 84\% from 12,346 in 1992 to 1,972 in 2005.\textsuperscript{70} This decline was directly attributed to the sobering-up centres in that state.

4.42 Sobering-up services in Australia were also reported to be valued and well-accepted by clients and the police\textsuperscript{71} as well as by local communities.\textsuperscript{72} However, evaluation evidence showed that the success of a facility is likely to depend on a number of factors. One of the most significant of these is that key stakeholders (including the police, local health authorities, service providers and the local community) need to be involved in the planning and decision-making process involved in setting up the service.\textsuperscript{73}

4.43 Much of the material available on North American sobering centres was not based on formal evaluation. Therefore, there is little specific information about the outcomes of these services. There was also little evidence on cost-effectiveness, although there was clearly a widespread belief that the use of sobering-up services avoided costs that would otherwise be incurred if people had to be taken into custody or to hospital.\textsuperscript{74} The evaluation of one American

\textsuperscript{67} Parliament of Victoria, 2000.
\textsuperscript{68} Brady et al, 2006.
\textsuperscript{69} Allen-Kelly et al, 2006; Parliament of Victoria, 2000.
\textsuperscript{70} Government of Western Australia, 2007.
\textsuperscript{71} Loxley et al, 2004.
\textsuperscript{72} Brady et al, 2006; Allen-Kelly et al, 2006.
\textsuperscript{73} Allen-Kelly et al, 2006.
\textsuperscript{74} Government of Western Australia; Bula, 2008; Rhodes, 2004; Ericksen, 2005;
service reported that a service for just six people accommodated 1,400 persons per year, had an annual cost of $145,000, and saved $50,000-$80,000 in police costs. It also reduced overcrowding in police cells.\textsuperscript{75}

4.44 At the same time, an Australian evaluation made the point that “a sobering-up facility is not a cheap option”.\textsuperscript{76} Cost-effectiveness is likely to depend partly on the size of the facility, but also on how well-used the facility is.

**Other services that address the care needs of drunk and incapable people**

4.45 The remainder of this chapter will briefly consider other interventions that are used around the world to meet the immediate care needs of drunk and incapable people. These include: transportation services; the provision of medical support within police custody suites (usually by custody nurses); and temporary places of safety / SOS bus services.

4.46 Compared with the evidence on sobering-up services, the volume of evidence available on other interventions was small; in the case of transportation services, this evidence has been gleaned from reports on other types of services (including sobering-up services). In these reports, the mention of a dedicated free bus or van service was mentioned almost in passing, although one North American study provided detailed information on the use of the sobering van in the city of Seattle over a five-year period.\textsuperscript{77}

4.47 In relation to the evidence on custody-based medical services, the literature is small, but of good quality – based on formal research and evaluation and published in peer-reviewed journal articles or government research reports.

4.48 The information about SOS bus services is taken from a single review report, carried out by Lothian & Borders Police in 2008. Data for the review was gathered from a combination of evaluation reports and interviews.\textsuperscript{78}

**Sobering service transport vans and night patrols**

4.49 There was evidence from both North America and Australia of transportation services working together with sobering-up centres.\textsuperscript{79} In some cases, these services were provided by the same agency that provided the sobering service.

4.50 Transport vans work by taking clients to and from the service free of charge. One American report stated that there were several vans associated with one sobering centre, and all the vans were staffed with an Emergency Medical

\textsuperscript{75} Santa Barbara County Grand Jury, 2001.
\textsuperscript{76} Allen-Kelly \textit{et al}, 2006.
\textsuperscript{77} City of Seattle, 2006.
\textsuperscript{78} Symington & Robbie, 2008.
\textsuperscript{79} In North America: King County Department of Health and Human Services, undated; Beaven, 2008; Alameda County Behavioral Healthcare Services, 2008b. In Australia: Brady \textit{et al}, 2006; Allen-Kelly \textit{et al}, 2006; Parliament of Victoria, 2000.
Technician and an outreach worker.\textsuperscript{80} In some cases, the vans may patrol city streets to pick up intoxicated people; in others, they may be directed to intoxicated people by the police.

4.51 In Australia, the use of night patrols is also common, and in some cases, the community night patrol provides a transportation service. The night patrol is a form of community policing which aims to reduce alcohol-related conflict and harm, and to resolve problems within the community before they get to a stage of requiring police intervention.\textsuperscript{81} Some are operated entirely by volunteer members of the community working on a weekly roster system, and others are staffed by paid workers. In the latter case, the available funding can put restrictions on the number of nights the service is able to operate.

4.52 There have been several evaluations of night patrols in Australia, and the findings clearly indicate that, where they operate, people generally have rated the patrols as effective in reducing alcohol-related violence and getting intoxicated people off the streets.\textsuperscript{82}

\textbf{Providing medical support in police custody suites}

4.53 In recent years, research has been carried out to analyse and quantify the burden on police custody suites of alcohol-related detentions. Two UK studies (funded by the Home Office) have investigated this issue.

4.54 Man \textit{et al} (2002) carried out an analysis of 1,575 custody records from three metropolitan police stations in England (in February 2000). This study found that alcohol was a factor in almost a third of arrests. In analysing this data, the researchers made a distinction between \textit{alcohol-specific offences} (such as drunkenness or drink driving) and \textit{alcohol-related offences} (where the detainee was drunk or had been drinking prior to the arrest). Alcohol-specific offences comprised 15\% of arrests and alcohol-related offences comprised 16\%. Both alcohol-related and alcohol-specific offences were most likely to occur at night – particular Friday and Saturday nights.

4.55 Compared to other detainees, alcohol-related detainees spent \textit{significantly longer} in custody (average of 8.7 hours compared with 6.9 hours) mainly because of the need to sober up before interviewing and processing. Alcohol-specific detainees spent \textit{less} time in custody (average 4.5 hours). Many alcohol-specific detainees were held until they sobered up, then were released without any charges being brought. Similar findings were also reported from an observational study carried out by Deehan \textit{et al} (2002).

4.56 Man \textit{et al} (2002) questioned whether the custody suite was an appropriate place for \textit{alcohol-specific} detainees – i.e., those who were often held in custody only to sober up, then were released. On the other hand, it was not seen to be appropriate to divert \textit{alcohol-related} detainees from custody, since

\textsuperscript{80} Alameda County Behavioral Healthcare Services, 2008b.
\textsuperscript{81} Parliament of Victoria, 2000; Curtis, 1993.
\textsuperscript{82} Loxley \textit{et al}, 2004.
many had in fact, committed an offence. Nevertheless, individuals arrested for alcohol-related offences still posed a significant burden on the police compared with those who had not been drinking, and required care from an appropriately trained individual.

4.57 Two other research studies in the UK have specifically investigated the role of the forensic medical examiner (FME) in addressing alcohol-related problems of drunken detainees in police custody — however, the focus of the articles was on exploring a possible role for the FME of providing brief interventions to detainees in custody.\(^{83}\) Neither of these studies looked specifically at the effectiveness of using FMEs to manage the care needs of drunk and incapable people in police custody.

4.58 Nevertheless, there were a few messages from these studies which are relevant to the aims of this review:

- A large part of the job of an FME involves assessing the fitness of alcohol-related detainees to be held in custody.
- One of the reasons for this may be that custody sergeants feel anxious about this group, who represent one of the most common groups to die in police custody.
- Although FMEs generally feel confident about caring for the needs of alcohol-related detainees, they question whether it should be part of their role to screen people for alcohol problems or to deliver brief interventions, and they question the effectiveness of such interventions being delivered in a police cell when an individual is intoxicated.

4.59 In recent years, there has been a growing trend in the UK and elsewhere to restructure services so that initial medical contacts among police detainees are made by custody nurses, rather than by the FME. Four studies were identified which examined the role of custody suite nurses. However, none of these concerned the specific role of nurses in meeting the needs of alcohol-related detainees. One study was not relevant at all to the purposes of this review. The main purpose of the other three studies (two in Melbourne, Australia and one in the north of England) was to evaluate the impact of providing nursing care in police custody suites in parallel with medical support from a forensic medical examiner.\(^{84}\) All studies found that the use of custody nurses can significantly improve the operational efficiency of health care services offered in police custody suites.

4.60 It is perhaps worth mentioning that one of these studies analysed the time nurses spent on different tasks, and found, as with FMEs, that the vast majority of the work of the nurses (approximately 90%) involved assessing an individual’s fitness to be detained and/or interviewed by the police.\(^{85}\)

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\(^{83}\) Deehan et al, 1998; Best et al, 2002.


\(^{85}\) Bond et al, 2007.
Temporary places of safety / mobile services / SOS buses

4.61 Finally, a model of service which is being used increasingly to meet the needs of drunk and incapable people in the UK, involves the use of mobile services or specially adapted buses.

4.62 The Mobile Medical Response Unit (MMRU) in Cardiff is an example of the former. This service comprises a triage vehicle staffed by a driver and paramedic, which is supported by a number of patient transportation vehicles provided by St John Ambulance and the Welsh Ambulance Trust. The MMRU has a police radio and can respond to 999 calls directly. On occasions of particularly high demand, a temporary treatment centre (a first-aid post located in the Millennium Stadium) is available where people with minor injuries can be referred. Patients who require further treatment are taken to the local emergency department.

4.63 In its first year of operation, the MMRU was available on 17 occasions, and the treatment centre also operated on eight of those occasions, during periods of peak demand. Alcohol was reported to be a factor in 96% of incidents dealt with by the service. A formal evaluation of the service concluded that it provided patients with a rapid and effective means of treating minor injuries, while freeing up emergency resources (police, ambulance and emergency departments). The service was estimated to save a total of 360 hours of emergency department time. In financial terms, this represented an estimated £14,445 in doctor costs alone.

4.64 At the same time, service delivery costs were kept very low because much of these costs were borne directly by the agencies involved in planning and delivering the service. For example, the vehicles were provided at no cost by St John Ambulance and the Welsh Ambulance Trust, and volunteer paramedics and nursing staff were provided by St John Ambulance for a relatively small donation. The direct costs of the service on each occasion of operation were £310.05 for the MMRU (total £5,271 for 17 occasions), and £1,044 for the treatment centre (£8,352 for eight occasions). These costs do not include the costs of nursing staff or police, which were available on some, but not all occasions.

4.65 Like the MMRU, SOS buses provide immediate assistance to people who may be intoxicated, distressed or have minor injuries. They offer first-aid (including, in some cases, emotional first-aid), and a place of safety for people until they are able to be taken home by a family member, friend or taxi.

4.66 There are SOS buses in Norwich (since 2000), Weston-Super-Mare (since 2005), Southend-on-Sea (since 2006) and Belfast (since 2007). In every city, the bus project is a multi-agency initiative involving the local authority, police, St John Ambulance, the local community, churches and charitable agencies.

86 John, 2006.
87 All the data on SOS buses is taken from a single review carried out on behalf of Lothian & Borders Police: Symington & Robbie, 2008, pp. 24-38.
4.67 The service works by parking the bus in a busy, prominent, city-centre location at night. A support vehicle (a van or mini-bus) is used to transport people to the bus from around the city, or from the bus to a hospital emergency department, if necessary. In some cases, the support vehicle may also take people home. In addition, clients may present themselves or be brought along by friends. In Norwich, the bus works together with a first-aid centre (located separately in a porta-cabin some distance away).

4.68 The buses generally operate at the weekends, although the Belfast SOS bus is also used during the week for educational and community project work.

4.69 In general, the clients are young people on a night out. In Weston-Super-Mare, steps have been taken to prevent the service being used by homeless people, by providing alternative services and shelters when the bus is on the street. There is an average 30-minute turnaround time for all clients, and the different bus projects have reported assisting between 8-9 clients (Norwich) to 400 clients (Belfast) per night.

4.70 Several of the bus projects are run as charitable endeavours and have received substantial donations (including donations of the bus and / or support vehicles) from the local community. Some have also been supported financially and in-kind by local businesses, nightclubs and the licensed trade.

4.71 Costs of the projects have varied. The Belfast bus is significantly more expensive than the others partly because the Belfast bus is larger (it is a 60-foot ‘bendy bus’ purchased from The Netherlands), and partly because the Belfast bus is used for other activities during the day.

- Norwich: annual running costs, £43,000
- Belfast: initial fitting-out costs, £350,000; annual running costs, £200,000.
- Southend-on-Sea: £150,000 initial costs; annual running costs, £50,000
- Weston-Super-Mare: £20,000 initial costs; running costs, £378/night + annual costs of £1,000 for MOT, repairs and fuel.

4.72 Although the primary purpose of the SOS buses has been to provide a place of safety to vulnerable people, evaluation of some of them has shown they have also been successful in diverting people who are intoxicated (and those with minor injuries) from emergency departments, ambulances and police cells.
5 SERVICES FOR DRUNK AND INCAPABLE PEOPLE IN SCOTLAND

Summary of main points

- There are services in a number of areas of Scotland that offer care to drunk and incapable people. The main types of services are: (i) permanent premises providing a 24-hour service, seven days a week; (ii) temporary triage or first-aid facilities operating at weekends or for special events; and (iii) other services such as custody nurses, police and ambulance protocols, and cell monitoring systems.

- These services were seen to perform a dual function. They relieve pressure on emergency services, primarily the police, but also hospital emergency departments and the ambulance service. In some cases, they also offer a place of safety and/or care to people who are vulnerable and at risk.

- Some services, such as the designated places in Inverness and Aberdeen, not only provide a place for people to sober up, but also attempt to engage with clients and offer advice, information, and in some cases, referrals to other services. There is less opportunity for this kind of intervention in the other types of services but there was a view that there should be some attempt to offer brief interventions, or in the case of chronic drinkers, to refer them to treatment.

- Service users unanimously agreed that if a person is drunk, but not violent, there should be other options to being taken into police custody. For service users, the preferred option would be for the intoxicated person to be taken home, or to be able to phone a contact person to collect them from the police station. However, there was broad support for the idea of making a very basic facility available to look after people in this condition.

5.1 The previous chapter examined evidence on the way other countries have attempted to meet the needs of drunk and incapable people. This chapter looks at how the needs of drunk and incapable people are currently being met in Scotland.

5.2 The evidence presented in this chapter comes from a combination of face-to-face and telephone interviews with service managers and commissioners, and a cross-section of other relevant stakeholders in the area — e.g., representatives from the police, NHS, ambulance service, local authority, and the local ADAT — to get their views on the operation of the different services and the needs they are meeting. We have also drawn on local (unpublished) reports about some of the services.

5.3 Services to meet the needs of drunk and incapable people in Scotland were found in several areas. These included:

- Designated places (Beechwood House in Inverness and Albyn House in Aberdeen)
- Temporary services (triage and first-aid services provided in Glasgow, Aberdeen and Edinburgh)
• Other services or facilities (such as forensic liaison nurses / custody nurses, police and ambulance service protocols, and police cell monitoring facilities).

5.4 This chapter ends with a discussion of the findings of two focus groups with service users involved in community rehabilitation services in Glasgow. Many of the individuals involved in these focus groups had experience of having been arrested by the police for being drunk and incapable, and so they have a very personal perspective on this matter.

Designated places

5.5 Two services in Scotland, Beechwood House in Inverness and Albyn House in Aberdeen, are recognised as “designated places” under section 5 of the Criminal Justice (Scotland) Act 1980, updated by the Criminal Procedure (Scotland) Act 1995. These Acts give police officers discretion when they deal with people who are drunk and incapable (and who have committed no other offence) to take them to a suitable place designated for appropriate supervision and treatment.

5.6 The objective of both services is to provide a safe place for drunk and incapable people as an alternative to police custody. They are available to anyone who is drunk and incapable. No distinction is made between binge-drinkers and chronic, alcohol-dependent drinkers.

Beechwood House, Inverness

5.7 Beechwood House is run by Crossreach, the Church of Scotland Social Care Council. The service comprises two co-located facilities for people with substance misuse problems. These are a 24-hour designated place for drunk and incapable people where they can sober up safely and a residential rehabilitation service. The designated place also offers four support beds where people can stay for up to two weeks for respite and detox. The residential facility provides a rehabilitation programme over a four- or fourteen-week period. In addition, there are links to substance misuse treatment, mental health services, and advice services on housing, debt and bereavement counselling. Clients can access supported accommodation for up to two years at Cale House or at flats near Beechwood, also run by Crossreach, while working with these other services.

5.8 The designated place was established in 1990 by a partnership of the police and NHS Highland, the then Scottish Office, working with the Church of Scotland Board of Social Responsibility. The residential rehabilitation service was added later. Funding was initially from a three-year Section 10 Social
Work grant awarded by the then Scottish Office. Subsequently it has come from Highland Council social work department, although this is under review.

5.9 Annual funding is in the region of £700,000 which covers the four beds in the designated place, the additional four short stay support beds and the rehabilitation unit. The cost per bed per week is £465 (£96,720 per year for the designated place).

**Albyn House, Aberdeen**

5.10 Albyn House in Aberdeen was opened in 1983 by Albyn House Association Ltd. The police, the social work department and the then Scottish Office were involved in the initial steering group. The service is now run by Alcohol Support Ltd, a voluntary sector agency formed in 2006 by merging Albyn House Association Ltd and Alcohol Advisory and Counselling Service (AACS).

5.11 Albyn House has two co-located facilities. The first is a four-bed designated place where drunk and incapable persons can sober up in a safe environment. There is also a 14-bed hostel offering detox and respite, short-term support with health, legal or accommodation issues and / or a longer-term rehabilitation programme. Additionally, there is an aftercare service for people following rehabilitation and a number of support groups available to clients through Albyn House.

5.12 Like Beechwood, Albyn House initially had three-year funding from a Section 10 social work grant. Subsequently, Grampian Region and then Aberdeen City Council took on the funding through social work, and latterly NHS Grampian has also contributed funding. The core funding for the running of all three facilities has been in the region of £330,000 per annum. Payment is also made for the cost of caring for individuals as and when needed (spot purchasing of beds) which increases costs to over £500,000. The Aberdeen City Council contribution to the designated place is estimated to have been in the region of £130,000.

5.13 More recently, the Council has withdrawn funding and a final decision about future funding is awaited at the time this report was drafted.

**Facilities and operational procedures**

5.14 Both designated places have four beds, all in single rooms. At Albyn House, all the rooms have wash basins. Showers and laundry facilities are available.

5.15 Details of the operational procedures of Beechwood House and Albyn House are provided in Appendix C. However, a summary of these procedures is included here. Appendix C also contains information about staffing.

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88 Section 10 of the Social Work (Scotland) Act 1968 allows the local authority to make contributions, by way of grants or loans, to any voluntary organisation whose sole purpose is the promotion of social welfare.

89 This information comes from the service manager and a report produced by Aberdeen City Council.
Admission / referral

5.16 For both services, the majority of referrals come from the police. Both services also accept referrals from the local hospital emergency departments, and in Inverness, Beechwood House accepts referrals from NHS24, GPs or community psychiatric nurses. In Aberdeen, referrals have also come from the social work department, including Criminal Justice social work, the Cyrenians and the Council’s Homelessness Unit. Self-referrals are not accepted at either service.

5.17 Neither service accepts people who are behaving violently or aggressively. Beechwood operates exclusion lists (permanent and three months) of people who have behaved violently to staff or other residents in the past, or who refuse to abide by the rules of the service. Albyn House excludes anyone with a court case pending because of an assault on staff (a rare occurrence), however no-one is barred permanently.

5.18 The police undertake Police National Computer checks prior to delivering a person to the designated places. Anyone facing criminal charges or with a history of violence or sexual offences is taken to police cells. Anyone with an injury may be taken to the emergency department or a GP. If the police consider the person as “suitable” for the designated place, they phone to notify staff.

5.19 When the client arrives, they are breathalysed. If their breath alcohol level is the equivalent to a blood alcohol concentration (BAC) of 100mg per 100ml of blood, they are admitted. If it is over 400 and/or staff are concerned about injuries or suspect a medical condition, the person is taken to an emergency department. However, they may later be referred back to the designated place. At both designated places, a risk assessment is carried out at admission.

5.20 Admission is voluntary in both services, and clients are free to leave at any time. However, if the client’s breath alcohol level is equivalent to 100 BAC, or if they are still deemed to be at risk when they leave, staff notify the police.

During their stay

5.21 Clients are monitored visually every 10-15 minutes when they first arrive in the service. After a period of time, the frequency of monitoring decreases. At Beechwood House, all rooms have windows, so staff can see from outside the room if clients are breathing or have vomited. At Albyn House, staff monitor clients by entering their room. In addition, all rooms at Albyn House are fitted with a Cell Occupant Monitoring System, which uses a radar transmitter to detect whether the occupant of the room is still breathing. An alarm system alerts staff to cardiac or respiratory arrest.

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90 In the UK, the legal limit for drivers is 80 mg of alcohol per 100 ml of blood, often referred to as a BAC or blood-alcohol concentration. This can be alternatively expressed in terms of breath alcohol – 35 μg (microgrammes) per 100ml (which is now the usual official measure in the UK).
5.22 Both services are licensed to administer diazepam to ameliorate the symptoms of alcohol withdrawal if a prescription is provided by a medical professional.

5.23 Clients may shower if they wish once they are sober, and staff will offer to do laundry and provide spare clothing to clients who use this service. Non-alcoholic drinks are offered, and at Beechwood a light snack / sandwich may be given in the morning provided the person is sober. There is no charge for this.

Exit procedures

5.24 In the morning, staff at both Beechwood House and Albyn House will attempt to engage with clients to ask whether they would like further support – either with an alcohol problem, or with other issues such as housing, bereavement, debt, etc. Referral arrangements can be made during this time as necessary. At both services, clients are offered a stay in a short-term support bed and / or may also move into the co-located residential rehabilitation service.

5.25 Managers suggested that first-time clients are often embarrassed and want to leave as quickly as possible, but others will take time to discuss with staff how they ended up in the designated place.

5.26 The client’s clothes and property are returned and records are updated.

5.27 Data provided by Beechwood House and Albyn House for the period April 2007 – March 2008, indicated that after discharge, most clients went home. However, in both services a number of discharges were also recorded as homeless, or of no fixed abode.

Perspectives of stakeholders

5.28 In both Inverness and Aberdeen, stakeholders felt that the main impact of the designated place was that it had provided a place of safety for drunk and incapable people, and had reduced pressure on emergency services, including the police and emergency departments.

5.29 In both cities, all interviewees perceived the police to be the main beneficiaries of the designated places. Police themselves argued strongly that, if the services were no longer available, the burden of caring for drunk and incapable people would fall upon them. This burden would be particularly heavy at weekends.

5.30 Grampian police have estimated that the additional costs that they would incur if Albyn House were not available are £330.16 - £456.32 per arrestee, or an
average annual cost of £130,556 (assuming 332 custodies per year of drunk and incapable people). These costs include:

- The initial response and transportation of the drunk and incapable person to a hospital emergency department or police cells
- Constant supervision of arrestees in police cells
- Police surgeon call-out time to assess the person’s fitness for being held in custody.

5.31 In addition, there was a feeling that the provision of a designated place had led to fewer prosecutions for public drunkenness. This also means that the person taken to a designated place would not have a criminal record. In Aberdeen, there was a view that the use of the service helped to prevent street incidents particularly in relation to assaults and anti-social behaviour.

5.32 All interviewees felt that the local emergency departments also benefited. In both Inverness and Aberdeen, emergency department interviewees felt that it was useful to be able to send intoxicated people with no other medical need to the designated place rather than having them occupy a bed in the hospital. In Aberdeen, the clinicians and managers in the emergency department at the Aberdeen Royal Infirmary viewed any possible reduction or withdrawal of the availability of the designated place as a serious concern because of demand on space and staff resources and disruption to other patients.

5.33 In both Inverness and Aberdeen, there was a view that the designated places also benefited the intoxicated individuals, who would otherwise be at risk of injury, assault or even death. It was also felt that the general public, to some extent, benefited, because the designated places helped get drunk and incapable people off the streets.

5.34 Scottish Ambulance Service interviewees offered a slightly different view. On the one hand, designated places were seen to be meeting a growing need. On the other hand, using an ambulance to transport drunk and incapable people from remote or rural areas to a city-centre location could take an enormous amount of time, and effectively removes an ambulance from other service during that time.

**Outcomes**

5.35 Stakeholders commented on the perceived outcomes from the designated places. These included a reduction of people in police cells, a reduction of people presenting to emergency departments, and intoxicated people being taken off the streets. However, an evaluation of outcomes was beyond the remit of this study and we have not collected any evidence of such outcomes.

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91 Communication from Grampian Police and the report on the Alcohol Related Disorder Profile of Aberdeen city centre produced for The Aberdeen City Alliance (TACA) — the overarching Community Planning Partnership
5.36 It is perhaps worth noting that there have been two deaths in Albyn House since 1983 out of around 19,000 referrals. As a result of these deaths, a Cell Occupant Monitoring System was installed in 2004. One individual also died in police custody in the process of being referred to the designated place in March 2008. At Beechwood House, there was one suicide in 1999.

**What works well**

5.37 In both Inverness and Aberdeen, the proximity of Beechwood House and Albyn House to the local hospital emergency department was seen to be helpful, as clients could be easily sent there if necessary for further assessment and treatment. They could also easily return to the designated place following discharge from the emergency department. In Aberdeen, the location of the service in the city centre was also reported to work well.

5.38 Stakeholders in Inverness spoke positively about the pathways that were offered by Beechwood to clients wanting to address their alcohol problems, either through the residential service, or through referral to other services.

**Temporary services (triage and first-aid)**

5.39 Some areas have put temporary services in place to meet the needs of people injured on the streets at particular times or special events. While the target group may be broader than people who are drunk and incapable, this group tends to represent a significant proportion of those who present to these services. We looked at three examples in Glasgow, Edinburgh and Aberdeen.

**Glasgow City**

5.40 In Glasgow, a pilot mobile medical resource (MMR) and supporting first-aid post operated over the four weekends of the Festive period from Friday 14 December 2007 to Sunday 6 January 2008. It was part of the multi-agency ‘Nite Zone’ strategy for managing the city centre’s growing night time economy. This strategy includes upgrading street lighting, extending CCTV and ‘authority figures’ to manage queues for night transport. The festive period is a major focus because of extra social drinking.

5.41 The MMR was based on a service in Cardiff (described briefly in the previous chapter). One difference, however, was that in Cardiff the service had an alcohol-related ‘holding centre’ which offered treatment and referral services, through social services and the local health board. In Glasgow, the Health Board was not involved.

5.42 Although the target group for the service was not specifically drunk and incapable people, a high proportion of the people dealt with by the MMR and first-aid posts were intoxicated. The MMR project had two elements:

- An ambulance and two paramedics available between 21.30 hours and 05.30 hours to respond to incidents in the city centre, triage patients on site, decide on further medical needs and treat or transport as appropriate
A static first-aid post at Central Station staffed by two members of the British Red Cross during the same hours to treat minor injuries.

5.43 Glasgow City Council funded the pilot project using monies from the Scottish Executive ‘Safer Streets 2007-2008’ bid. The overall cost of running the project was £9,432.90 for the four weekends:

<table>
<thead>
<tr>
<th>Service</th>
<th>Costs/Details</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scottish Ambulance Service</strong></td>
<td>Costs of 2 x Ambulance Paramedics @ £897.11 per night</td>
<td>£7,176.90</td>
</tr>
<tr>
<td></td>
<td>Costs of Ambulance per night</td>
<td>£0</td>
</tr>
<tr>
<td><strong>British Red Cross (Static First-aid Post)</strong></td>
<td>Costs of 2 x First Aiders for 8 nights @ £188.00 per night</td>
<td>£1,504.00</td>
</tr>
<tr>
<td></td>
<td>Costs of Ambulance @ £94.00 per night</td>
<td>£752.00</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>£9,432.90</strong></td>
</tr>
</tbody>
</table>

Staff were paid overtime rates.

**Operation of the service**

5.44 The Scottish Ambulance Service operated a triage protocol. Staff were on duty in the city centre between 21.00 – 05.00 hours, Fridays and Saturdays, providing an additional, dedicated resource based at the first-aid post. They responded to calls for assistance from the police, city council and general public (self presenting and via the Emergency Medical Dispatch Centre / 999 system). An examination and assessment of each patient was carried out. Options were:

- No treatment required
- Examine and treat on scene
- Move to British Red Cross post for first-aid treatment
- Move to nearest emergency department for treatment (life threatening)
- Rendezvous with normal ambulance resource to uplift patient to nearest emergency department (non life threatening).

**Impact**

5.45 An evaluation of the service found that, over the four weekends, 96 people (67 males and 29 females) were treated either by the paramedics or British Red Cross volunteers. The overall average age of those treated was 29 years. Alcohol had been consumed by 81 individuals (84%) and five individuals were treated specifically for intoxication. Only 25 patients required hospital treatment while 60 were treated on-site.

5.46 The overall consensus among partner agencies was that the presence of the dedicated mobile medical resource over the festive period had contributed positively to public safety, and that it had almost certainly contributed to a reduced volume of patients at the emergency department and a reduction in crime.
Perspectives of stakeholders

5.47 Some stakeholders, including the Scottish Ambulance Service, would like to see a dedicated ambulance resource every weekend in the city centre. At the very least, there was a feeling that the MMR service should be repeated over the festive period and extended to cover other weekends and major events such as football matches. However, one ambulance service interviewee commented that, while they could fund vehicles, they needed support from the police and first-aiders. There was also an issue in that, if the ambulance service assessed an intoxicated person as needing no treatment, they had to wait for the police to come and pick up that individual because they could not leave him/her lying in the street.

5.48 Stakeholders also felt that there should be some attempt to offer brief interventions or, in the case of chronic drinkers, to refer them to treatment.

Aberdeen

5.49 In 2007, a triage facility was piloted in Aberdeen in response to the large numbers of people frequenting licensed premises in the city centre at weekends and sustaining injuries while under the influence of alcohol. The aim was to provide a speedier response to these needs and to relieve pressure on the emergency services. The service was planned to run over one weekend in June and four weekends from 30 November to 23 December from 22.00 – 04.00 hours on Friday and Saturday nights. However, staffing shortages meant that it did not operate on the last weekend before Christmas. The total time of operation was, therefore, eight nights over four weekends.

5.50 The triage facility was located in the boardroom at Albyn House.\(^{92}\) It had an additional objective to increase the referrals to the designated place. Referral was by 999 call to the Scottish Ambulance Service, via the police or by self-referral. The service was staffed by:

- Two ambulance technicians (after the first weekend, a doctor was replaced by the second ambulance technician for financial reasons)
- Two police constables,\(^{93}\) to carry out police computer checks on those casualties eligible for the designated place, to note statements and to maintain order
- One manager and one social care worker from Albyn House for any admissions to the designated place
- Two consultants from NHS Grampian to undertake risk assessment and triage.

5.51 To use the service, patients had to be fully conscious with vital signs within normal parameters. Their airway, breathing and circulation (A B Cs) had to be stable. Anyone with a potentially life threatening condition or a head injury

\(^{92}\) Initially the triage facility was in a caravan but was moved owing to its dilapidated state.

\(^{93}\) Separately funded through an Anti-Social Behaviour fund.
were taken to the emergency department either by ambulance or by a patient transport vehicle.

5.52 An Operational Order outlining the police procedures was prepared in advance of the event, as well as a memorandum of understanding that detailed the referral criteria above and other relevant information including an operational flow chart.

5.53 Funding of £5,000 was provided from the Joint Alcohol and Drug Action Team (JADAT) and £6,084 from the Aberdeen Community Safety Partnership through the ‘Safer Streets’ initiative. Not all the funding was used because of the cancellation of the final weekend.

Outcomes and impact

5.54 Over the four weekends, 22 individuals used the service. Nine of these were admitted to Albyn House, four were taken to the Aberdeen Royal Hospital emergency department and nine were assessed and discharged.

5.55 Formal evaluation of the pilot showed that the ambulance service was able to save up to 30 minutes in transport time per patient not taken to the emergency department, potentially two-and-a-half hours on the busiest day of the pilot. In that sense, it was successful in reducing the burden on the ambulance service and allowing a faster response time to other 999 life threatening calls within the city. On the other hand, however, emergency department staff were unable to detect any difference in patient admissions.

5.56 From a police perspective the main benefit was seen to be an improvement in the overall “feel safe” factor in the city centre.

5.57 The number of casualties assessed by the triage facility was recognised to be low in comparison with other similar facilities in other parts of the UK. One of the reasons for this was the cancellation of the facility in the last weekend before Christmas which would have been the busiest weekend in the city centre. There had also been a successful policing operation of the city centre over the festive period which may have reduced the level of drunken behaviour.

5.58 The separate triage facility at the Hogmanay party treated 50 casualties in a 3.5-hour period and only seven needed to be taken to the emergency department. This was part of a comprehensive strategy to manage the Hogmanay event which involved a first-aid type facility in a marquee in a car park just off Union Street, and an ambulance on stand-by. There were also three points where people who were drunk could sit and be monitored by door stewards and police.

Perspectives of stakeholders

5.59 Overall, the partners felt that it was worthwhile to look at ways of developing and improving the triage model so that it might be a more effective option for the future. Options include:
- The Scottish Ambulance Service directly referring drunk and incapable individuals to Albyn House without waiting for police checks. Where cases involve persons well-known to all three agencies, this could save significant time and resources.

- Operating a triage facility within Albyn House, using personnel not just from the police, ambulance service and Alcohol Support, but also volunteers from the Aberdeen Street Pastors. The Street Pastors could potentially work alongside an ambulance crew in a patient transport vehicle to identify vulnerable or injured individuals and, where appropriate, convey them to the triage facility.

5.60 Other views were:

- Some effort should be made to give advice / education to young people once they are sober
- The licensed trade should take some responsibility for preventing people from becoming so intoxicated
- The partnership approach should be continued and should involve the NHS, ambulance service, police and social services.

**Edinburgh**

5.61 Edinburgh has had a Hogmanay ‘sleep-over’ facility at St George’s West Church for over ten years. It is managed by a doctor from Lothian Medicover, part of Polwarth Surgery. The facility is for people who have had drink-related injuries and who may be at risk of exposure. People arrive at the facility by ambulance from the four first-aid posts in operation along Princes Street. Referrals are not encouraged from any other source but people can self-present.

5.62 People are supervised until they are sober enough to be taken home by social work mini-buses or by other means (family, friends, taxi). Their details are documented as they enter but no background / police checks are carried out as a matter of course. The triplicate admission form serves as a referral letter should further treatment be required at the emergency department.

5.63 Staff carry out a medical assessment of the person’s level of intoxication and decide whether transfer to hospital is required.

5.64 Facilities are basic. The furniture is cleared from the church hall and plastic sheeting laid out on the floor to provide a large sleeping area for approximately twenty people. Water, toilets and blankets are available and a kitchen with tea and coffee making facilities is available. Lothian Medicover provides all necessary medical equipment and supplies.

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94 The information about the Edinburgh Hogmanay facility has been taken from a report by Sergeant Lynne Symington and Constable Rowena Robbie of Lothian and Borders Police on "Care Facilities for Drunk and Vulnerable People".
5.65 There is no further intervention offered. The doctor in charge is of the opinion that those attending are, for the most part, not in any fit state to receive or retain information about alcohol misuse or safe and responsible drinking.

5.66 The facility is staffed by one doctor, two nurses and 12 voluntary first-aiders from the Red Cross. There are also two door stewards (Rock Steady) and two police officers to act as a deterrent for potential trouble. A church associate with knowledge of the premises is also on duty.

5.67 The City of Edinburgh Council finances the facility. The approximate cost is £6,000 to cover use of the hall, medical and social work staff. At Hogmanay 2007/08, approximately 20 casualties were treated.

**Perspective of stakeholders**

5.68 The Sleep-over has been operating for a number of years and the procedures were reported to work well. The main beneficiaries were seen to be the police, Royal Edinburgh Hospital emergency department and the ambulance service. Stakeholders also felt that having an identified place to take drunk and incapable people during the Hogmanay festivities reduced the pressure on the police who could spend more time policing the streets.

**Other services**

**Forensic liaison nurses / custody nurses**

5.69 There are six custody nurses who provide an out-of-hours service at St Leonard's Police Station, 7.00pm to 7.00am Monday to Friday, and all day Saturday and Sunday. One nurse is peripatetic and can be called out to other police stations in the Lothian and Borders area, e.g., Dalkeith, Hawick and Livingston. The custody nurses all have training in drugs and alcohol problems, and five nurses have mental health nursing backgrounds.

5.70 The annual budget of £301,455 covers the cost of six nurses (plus any backfill for holidays, sickness, etc.).

5.71 The nurses provide a triage service to people who are deemed by custody staff to be at risk. This includes people who have medical conditions or ailments such as asthma or diabetes. The nurses do not see all those who are intoxicated by drugs or alcohol but only those identified by custody staff as causing concern.

5.72 The nurses may provide basic first-aid in the cells, refer people to the emergency department, or advise custody staff that the person should be observed. If there is any concern during the observations, the nurse will examine the person.

5.73 When people leave the cells, the nurse may see them a second time. This is more likely at weekends as, during the week, they may already have gone off duty by the time the individual leaves the police station. If possible, they offer
a minimal intervention. The nurses have undertaken brief intervention therapy training with funding made available by the Scottish Government.

**Perspectives of stakeholders**

5.74 Interviewees felt that the impact of the custody nurses has been to reduce pressure on the police in the custody suite and to reduce the number of visits required to the emergency department. In the future, it is hoped that the nurses will have greater opportunities to offer counselling and brief interventions.

5.75 It was reported that there were initially some challenges for the custody staff and nurses to adapt to their respective roles, but stakeholders felt that they now work well as a team.

**Protocols**

5.76 Some areas have developed protocols between the police and ambulance service to deal with the assessment and referral or treatment of people who are drunk and incapable.

**Fife**

5.77 For around two years, a Memorandum of Understanding (MOU) has been in place in Fife between Fife Constabulary and the Scottish Ambulance Service setting out how to handle people who are drunk and incapable in public places. On receipt of the initial report, the ambulance service call handler will gather as much detail as possible to ascertain if police attendance is necessary. If not, the call handler obtains information about the nature of the incident and the physical condition of the person, e.g., signs of bleeding or difficulty in breathing, before summoning an ambulance. Once ambulance service personnel are at the scene, they will undertake an assessment following standard clinical guidelines. People may be treated and left, or taken to an emergency department, unless an offence has been committed which would require them to be taken in police custody.

5.78 There are mixed views about the effectiveness of the MOU. Stakeholders from the ambulance service reported a significant increase in calls to attend drunk and incapable individuals. However, they consider that, while the geography of Fife and the locations of police cells and hospitals support the arrangement, it may not be possible to cope with the increased demand in other areas of the country. Even within Fife, there are occasions when ambulances have to travel long distances to attend to someone who is drunk and incapable. This diverts ambulances from regular calls and it affects performance against targets. The Association of Chief Police officers (ACPOS), on the other hand, has asked all forces to engage with their local health boards with a view to introducing similar schemes across Scotland.

5.79 There is also a joint NHS and ambulance service pathfinder project in West Fife involving the use of a vehicle and a response team, normally comprising an emergency care practitioner nurse and a paramedic. The team can assess
and treat patients in the community and, if necessary, refer them on for further treatment. The pathfinder project was developed by the ambulance service as a way to reduce the impact of the MOU. The pathfinder is seen as a way to ensure that people who are very intoxicated are fit for detention, and it also reduces the number who have to go to a hospital emergency department. It is hoped to develop the pathfinder in East Fife.

**Edinburgh**

5.80 In Edinburgh there is also a joint protocol between the police and ambulance service on how to deal with drunk and incapable people. The ambulance service call handler will check if a criminal offence is involved which might require police attendance. If the police are not required, the call handler will obtain information about the person’s condition and send an ambulance. A person can sign a Patient Refusal Form to decline assistance, but if they are unable or unwilling to sign it, they are taken by ambulance to the emergency department to be assessed by a doctor.

**Cell Monitoring**

5.81 In 2006, Grampian Police fitted life monitoring equipment in six cells, two of which also have observation facilities. There are wave sensors in the cells linked by radio to a computer. These sensors monitor and measure various types of movement and noises. A monitor displaying the sensor readings for each cell is located within the custody reception area and neighbouring CCTV control. The equipment became operational in March 2007.

5.82 The custody officer carries out a comprehensive risk assessment on arrestees, which includes all known or suspected medical, mental health, drug or alcohol issues and also their general demeanour and behaviour. The six life monitoring cells are used at all times, but when the cells are busy, they are occupied by those who are identified or suspected of having a recognised risk, including people heavily under the influence of alcohol or drugs. Where an unacceptably high risk is identified or the custody officer is not sure about the risk, a doctor is always contacted and asked to examine the person to confirm that they are fit to be detained.

5.83 It is important to note that Grampian Police view the life monitoring system as an additional aid to custody officers to reassure them between visits to the cells. People in cells are still visited on five, ten, 15 and 30-minute cycles depending on risk assessment and general demeanour. There are also still occasions when a person may be put on constant supervision in an observation cell fitted with life monitoring.

5.84 We have set out above the operation of life monitoring as it has been described to us in an official communication from Grampian Police. However,  

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95 This information comes from written communication with Grampian police in October 2008.
we are aware of some concerns among the police about problems with the functioning of the system on occasion, which may lead to a review of its use.

**Perspectives of service users**

5.85 In focus groups at two community alcohol rehabilitation agencies in Glasgow, service users were asked about their views on the needs of drunk and incapable people. It is worth noting that, many of the 17 people who took part in these focus groups had previous experience of being arrested by the police for being drunk and incapable and therefore, had a unique perspective on this issue.

**Current situation**

5.86 Service users were asked to give their views on the current situation — when a person is identified as drunk and incapable in public and is arrested by the police and taken into custody for their own safety.

5.87 Service users in both groups agreed that it is necessary to intervene when someone is putting him / herself at risk because of severe intoxication. This need for intervention was seen to be especially important in relation to women, who may be at risk of sexual assault. However, both groups strongly felt that police cells were not the best place for a drunk person.

5.88 Those with experience of being held in police cells when drunk, did not perceive that the police undertook any monitoring of people in this condition. While this perception may not be entirely accurate, several in the group recounted stories of calling for help and being ignored: “If you shout for help, the police just ignore you; they think you’re just drunk, that you’re a pain”. One individual said he told the police he needed to take medication, but he was not assessed by a doctor during his period in custody. Another individual said that she had been forced to undergo alcohol withdrawal over a weekend without any access to a medical professional.

5.89 None of the service users who took part in the focus groups had any experience of receiving a medical assessment when they were drunk in police cells. Moreover, none of them had experience of being offered advice, support or other help regarding their drinking, before being released, although all of them believed that they should have been.

**What would service users like to happen?**

5.90 There was unanimous agreement among service users in both groups that, that there should be other options to being taken into custody.

5.91 There was a very strong message from both groups, that the *preferred* option would be for the intoxicated person to be taken home, or to phone a contact person to collect them from the police station. In general, people preferred this option even if there was no one at home to look after them, despite
knowing the risks. Some argued that a drunk person could still die at home even with other people in the house.

5.92 A small minority in both groups conceded that, if there was no one at home, or no one able to collect them, then it probably would be safer to be kept in police cells. However, this group felt strongly that, in this case, there should be a medically-qualified person available (this could be a nurse) to undertake an assessment of every intoxicated person who comes into the cells. Furthermore, every person who was drunk when arrested should be offered advice and support in the morning. The view was expressed that, “Taking someone into custody lets them sober up safely, but it doesn’t solve the problem”.

5.93 It is worth noting that service users in both groups felt that, “If a person is just drunk and not violent, he just wants to get home”. However, in the views of these individuals, the problem arises between leaving the pub and getting home, as taxi drivers will often refuse to take drunk passengers.

What about other possible alternatives to police custody?

5.94 Service users were specifically asked their views about whether it would be helpful to have a “unit” or “facility” where intoxicated people could be taken to sober up safely under the care of medically-trained staff — as an alternative to police cells. In general, both groups were in favour of this idea. However some still felt that their first preference would be to be taken home. It was suggested that such a facility should only be used if there was no one at home who could look after the intoxicated person.

5.95 As there was support for the idea of such a facility, service users were then asked what they thought it should look like. In general, both groups thought the facility should be very basic. The view was expressed that if it were too comfortable, people would use it all the time. If it is basic, people will be more likely to think, “I could have been at home”. One individual said she would be happy to just sleep upright in a chair, so long as it was warm and safe.

5.96 There was agreement that the facility should offer tea / coffee, somewhere to sit down, staff with medical (or first-aid) expertise, toilets and wash-hand basins. If there was a place to lie down, the feeling was that folding beds would be adequate. Males and females should be able to rest / sleep in separate rooms, and there should be good security to prevent trouble. There was disagreement about whether the facility should offer a change of clothes or laundry facilities. Some felt it could be a salutary experience for a person to wake up in the morning in clothes that they had soiled the night before. Others felt that offering a change of clothes or the option of laundering clothing would communicate care.

5.97 There was debate about whether the facility should accept people who are intoxicated with drugs, as well as alcohol. One person felt that the needs of these groups were very different, and it might be difficult for a single service to accommodate those needs. However, the service users generally believed
that the needs of both groups were the same on the night, but had to be addressed differently in the morning. There was a strong feeling that an important aspect of any such facility is that its staff offer advice, information or counselling in the morning (or before the person leaves).

5.98 Service users very strongly believed that providing a bus to transport people to the facility would not work, because of the risk of violence. If transportation were offered, people would need to be transported individually. Some felt it would be safest if people were taken to the service by the police. Although this means the police are effectively providing a taxi service, the view was that they would still saving time, because the person is not being taken to a cell.

5.99 When asked where such a facility should be located, the general view was that it should be located in a city centre, near to a hospital. However, the facility should also be available to outlying areas.

What if it’s not possible to afford such a facility?

5.100 Finally, service users were asked what they thought should happen if it were not possible to fund such a facility. An individual in one group stated that:

“If the government are serious about helping people who have alcohol problems, this is a good way of doing it, because you’re really reaching people that are difficult to reach”.

5.101 However, an individual in the second group argued that “the drinks industry should help fund it”. This proposal received considerable support from other service users.

5.102 Overall, the service users in both groups felt that a great deal could be done to improve the current situation, simply by allowing people to phone someone at home to collect them when they were arrested by the police, or by providing better medical care to intoxicated people in police cells.
6 DISCUSSION AND CONCLUSIONS

6.1 The purpose of this research was to identify what need there is in Scotland for services for people who become drunk and incapable in public. This has involved not only estimating the size and nature of the problem, but also looking in detail at how the needs of this population are currently being addressed, both in Scotland and elsewhere, and how those needs may be addressed most effectively.

6.2 This chapter summarises the main messages from this research, considers the strengths and limitations of different types of services and offers some conclusions and recommendations.

What need is there for services in Scotland?

6.3 The question, what need is there for services in Scotland, includes two subsidiary questions. The first is, what is the scale of the problem? The second is, what is the nature of the need?

6.4 Considering the scale of the problem first: based on our examination of secondary data sources we estimate that:

- There are between 7,500 – 21,000 drunk and incapable people per year presenting at hospital emergency departments at an estimated cost of between £0.7m and £1.95m per year.
- Across Scotland, there is a relatively small number of people being admitted to hospital with a primary diagnosis of acute intoxication — 1,440 people per year. However, the cost associated with their care in an acute hospital ward is high — an estimated £0.7m per year.
- In addition, there are around 5,500 people per year arrested by the police and charged with the offence of being drunk and incapable. The cost of holding these people in police custody for their own safety is estimated to be around £2.12m per year.

6.5 The data indicated that at least some of the people arrested by the police are repeat offenders. It also seems likely that some people who are arrested by the police as drunk and incapable may also end up in hospital for the same problem on other occasions, or because they’re taken there by the police following arrest.

6.6 However, an important finding from the analysis of secondary data is that there is an absence of consistent and robust data on severely intoxicated people. This makes it difficult to obtain an accurate measure on the extent of the problem across Scotland and in local areas. There is no direct source of data on the number of people who are drunk and incapable coming into contact with emergency services who may be eligible for a different type of service. The lack of ambulance service data was also a significant gap. We therefore had to use various proxy measures, such as:

- The number of police charges for being drunk and incapable
• The number of hospital discharges with alcohol intoxication as a primary diagnosis and
• The estimated number of accident and emergency presentations of intoxicated people.

6.7 There are a number of weaknesses with these different datasets, primarily the potential variations in processing, recording and coding of data.

6.8 Therefore, although the data presented in our report provides a useful starting point, it is important that local areas supplement this with locally-gathered intelligence which may provide a more comprehensive and detailed picture of local need.

6.9 From our investigation of services that currently exist to manage the care needs of drunk and incapable people we have identified some common themes regarding the nature of the need in Scotland:

• The first is that there is a need for an alternative service — or services — to reduce the pressure on the time and resources of the emergency services which is caused by severely intoxicated people. Both the police and hospital emergency departments would benefit from alternative services, and both argued strongly for such services.

• Second, there is a need to keep publicly intoxicated people safe until they sober up. Where the individual does not have a responsible person who can look after them, this task must fall to some form of service.

• Finally, there is a need for services to link people more effectively to treatment and support, where appropriate, and / or to deliver brief interventions to reduce drinking levels among binge drinkers. However, the feeling was that people had to be sober first to be able to benefit from such interventions.

6.10 There is also another group for whom some provision may have to be made. These are people who are arrested for an offence (such as assault), but who are also intoxicated and, therefore, vulnerable. Because of the offence these individuals will have to be detained in a cell but they still require to be assessed and monitored. It was beyond the scope of this research to estimate the size of this population. However, the view was that the tasks of assessment and monitoring should not be carried out by the police, but rather by a suitably-qualified medical professional.

What do services look like?

6.11 Both in Scotland and around the world, services for drunk and incapable people tended to fit into one of three models:

• **Premises** (permanent and temporary) where drunk and incapable people (who are not injured) can be kept safe and their physical condition monitored by trained staff until they are sober and able to go home. These premises can be very basic (mat on floor) or more comfortable (beds and
showers). They can operate 24/7, or on certain nights of the week. In the US and Australia, there were examples of these services operating together with a transportation service that collected people off the streets (or from police custody suites), and transferred them to the sobering-up facility.

- **Mobile units** which provide some level of assessment, triage and first-aid if needed. The target group for these services is usually wider than people who are intoxicated, although intoxicated people generally comprise a large proportion of their clients. These services range from mobile medical resource vehicles to converted buses and can be staffed by ambulance personnel, paramedics and volunteers. They mainly operate at weekends, at special times of the year, or for specific events.

- **Custody nurses** who provide an assessment of whether people are fit to be detained. Custody nurses can also treat minor injuries in police custody suites. They operate mainly evenings and weekends.

6.12 In Scotland, we also found examples of joint protocols between police and ambulance services for managing the care needs of people who are drunk and incapable in public, and we found cases where technology (cell monitoring systems) was used to support — but not substitute for — visual monitoring by staff.

6.13 In general, stakeholders felt that the best way to manage the needs of drunk and incapable people would be to provide a place of safety where individuals can sober up under the care of trained staff. There was strong support for the idea of a permanent sobering-up facility with dedicated premises operating round the clock. However, this was seen as expensive, in part because of possible under-occupancy during weekdays, and in part because it would cater for a relatively small number of people, after taking into account that some people will still have to be taken into custody (because they have committed an offence), or to hospital (because they are injured). There is also evidence from Scotland and elsewhere around the world that such services can end up being used frequently by a small number of alcohol-dependent drinkers.

6.14 Some people felt that mobile resource units and triage points were less expensive and might be better suited to meet the needs of intoxicated people in busy city centres. They can also deal with a larger volume of people. What was reported to be missing in the Glasgow pilot was a holding area for drunk people. In Edinburgh and Aberdeen, the triage services had access to space where people could wait until they were sober. In England, there has been some success in using specially adapted buses that have space to allow people sit and wait for short periods of time.

6.15 The use of custody nurses was not widespread across Scotland. There were some positive reports of this model of service. However, if other services for drunk and incapable people are not also made available, the use of custody nurses does nothing to divert people from police custody who do not really need to be there.
6.16 The issue of service funding was a recurrent theme in this study. There is clearly a need for a new approach to funding services. In both Inverness and Aberdeen, the funding for the designated place was under severe pressure. Where there have been temporary services, funding has been provided only on a short-term basis, with no guarantee of the service being repeated or extended.

6.17 One of the main difficulties seems to be that no one agency feels responsible for the provision of services for drunk and incapable people. This was seen to have an impact on funding. The findings of this research suggest that a multi-agency approach to funding will be required. In Scotland, this should at the very least involve the local authority, NHS (community and acute services), ambulance service, police and the voluntary sector. Both professionals and service users also argued for the licensed trade to be involved as well — not only in terms of discouraging excessive alcohol consumption by customers, but also in contributing towards the cost of it when it occurs.

What is seen as good practice?

6.18 A report published by HM Inspectorate of Constabulary for Scotland argues strongly that a police cell is not the best place for holding an individual who has committed no offence, but who is merely drunk and incapable of looking after themselves. Stakeholders, including service users, unanimously agreed with this view.

6.19 Therefore, one aspect of good practice in meeting the needs of drunk and incapable people at a local level is to ensure that alternative services are provided to divert severely intoxicated people from police custody. The experience of Australia shows that the introduction of sobering-up services can have a dramatic impact on the number of intoxicated individuals held in police custody.

6.20 Evidence from Scotland and around the world suggests that good practice in providing services for this vulnerable population requires:

- Locally-based needs assessment to get a more detailed picture of the local population of drunk and incapable people
- Multi-agency support, both at the planning and delivery stage
- Flexibility in commissioning services, as needs are likely to vary from one area to another, and they are likely to change over time
- Multi-disciplinary staff trained in first-aid and in the ability to recognise when more specialist clinical input is required
- Clear referral, admission and safety protocols and procedures

• Some form of brief intervention or referral to longer-term services providing treatment and/or housing support when the person is sober.

6.21 The latter point was emphasised, not only by professional stakeholders, but also by service users. It is the latter point that provides the link between harm reduction (keeping people safe) and prevention (encouraging a reduction in dangerous levels of drinking).

6.22 On the other hand, it was also recognised that it may take many attendances before an individual is willing and able to respond to interventions. One of the advantages of an overnight sobering-up service is that it provides an opportunity for engaging with service users in the morning when they are sober. In any case, there was a clear consensus among stakeholders that there should be more intensive efforts to try to help chronic drinkers, in particular, break the cycle.

**What are the options for services?**

6.23 The findings of this study suggest that a one-size-fits-all approach to services for drunk and incapable people is unlikely to address all the needs. Therefore, this study does not recommend that local areas should adopt a certain model of service. Different service models have different strengths and limitations, and it may be that the best approach will be a combination of models.

6.24 In deciding what type of service will best suit the circumstances of a particular local area, it is important that the objectives of the service be clarified. From our evidence we would suggest that there are three interlinked objectives:

- To keep vulnerable people safe
- To reduce the pressure on emergency services (police, emergency departments and ambulance service)
- To deliver interventions that will encourage people to reduce their drinking and prevent recurrence.

6.25 Arguably, the last of these objectives makes service design and delivery more complex and requires involvement from a greater number of agencies. The interventions would be different depending on the client. For binge drinkers, particularly young binge drinkers, the focus may be on brief interventions, advice and education. For chronic drinkers, the interventions will need to be more intensive and longer-term.

6.26 In considering the options, the issue of cost is obviously important. However, local service planners should also bear in mind the existing costs already incurred by the police, emergency departments and ambulance service in responding to the needs of severely intoxicated people. Ways of minimising costs might include:
• Providing premises for a place of safety and using those premises for other purposes during the week, e.g., health, social care or information services for problem alcohol users.

• Providing a place of safety within existing premises, e.g., police cells, hospital, social work or community centres, but ensuring that the monitoring function is provided by suitably trained staff.

• Installing life monitoring systems in police cells.

• Increasing the number of custody nurses available to assess and treat people intoxicated by both alcohol and drugs.

• Using mobile units which could be taken to different locations as needed at weekends when the problem is greatest, and deployed for other duties during the week.

6.27 Table 6.1 on the following page summarises the strengths and limitations of the three main service models we identified in Scotland and elsewhere, and compares their relative cost.
<table>
<thead>
<tr>
<th>Strengths</th>
<th>Limitations</th>
<th>Good practice</th>
<th>Relative cost</th>
</tr>
</thead>
</table>
| **Designated places / Sobering-up services** | • Diverts some people from police custody and emergency departments  
• Can be used as an alternative to emergency department for people with minor injuries, and can be used by emergency department to discharge people to  
• Provides a safe place for vulnerable people  
• Enables regular monitoring  
• Allows time and opportunity for brief interventions  
• Gives opportunity for further interventions / referrals  
• Permanent staff | • Requires premises and appropriate facilities  
• People must be taken to police custody if the service is not available 24/7  
• Large number of beds would be needed to meet demand in some areas  
• Possible under-use during the week  
• In Scotland, existing services do not treat minor injuries, although this would be possible with suitably trained staff | • Should have strong links to other services, including treatment and rehabilitation services  
• Staff should be trained in first-aid and have access to resuscitation equipment  
• Other training should include drug / alcohol awareness, suicide prevention and brief interventions  
• Provide with separate transportation to avoid police / ambulance acting as a taxi service | £££ |
| **Custody nurses** | • Gives people in custody access to a trained medical professional  
• Operates mainly at evenings and weekends when the demand is greatest  
• Operates in existing premises | • Does not divert people from police custody - police must continue to monitor the person’s care needs  
• Not all drunk detainees are seen by the custody nurse  
• Not currently available 24/7  
• Primarily available on an on-call basis  
• Does not divert people from emergency department  
• Difficult to provide brief interventions while the person is intoxicated | • Need to provide sufficient coverage so that waiting times for detainee assessment are short | £ |
| **Mobile units / SOS buses** | • Can be located where and when there are large concentrations of drinkers  
• Can respond to the needs of large numbers of people  
• Diverts people from custody, from need for ambulance and from emergency department  
• Does not require premises | • Not available 24/7  
• Aim is to get people out as quickly as possible (although some have space for people to stay for a few hours)  
• Does not address wider health and social care needs people may have  
• Difficult to provide brief interventions while the person is intoxicated | • Possible need to make alternative provision for homeless people  
• Linked to first-aid posts and access to a “holding area” where people can stay until sober. | £ |
In considering the best option(s) for different local circumstances, the following factors should be taken into account:

- **The target group:** Is the service primarily to ensure the health and safety of drinkers who occasionally become drunk and incapable and need immediate care before sobering up and returning home? Or will it offer a more intensive, perhaps more medical intervention for people with a serious, long-term problem?

- **The location:** Ideally, the service should be near to an emergency department, or a first-aid post, but it is also worth considering proximity to the main centre of population where drinking is mostly likely to occur, and to police custody suites. There is also the question of transport: how will people arrive at the service, and how will they leave it?

- **Capacity:** How many clients are likely to use the service? Static premises may only be able to accommodate limited numbers. A mobile facility may offer greater flexibility but that will be contingent on a short stay which may not be suitable for all clients. A mobile unit linked to a “holding centre” may be able to address some of these difficulties.

- **Level of comfort:** If it is a building, will it provide beds or mats on the floor, showers, food?

- **Hours of operation:** 24/7 or mainly at weekends and other times of peak demand? If the latter, what will happen at other times?

- **Number and level of staff:** Staff should have a mix of skills but should at minimum have first-aid training, including at least one member of staff with paramedic-equivalent training. Staff should also be able to provide brief interventions and onward referral when appropriate. If the service aims to address the problems of chronic drinkers in a more systematic and sustained way, it may require more highly trained or specialised staff.

- **Admission and exit criteria:** These criteria need to be agreed with other agencies that will refer or bring people to the service. For example, will the service be able to accept people with minor injuries?

- **Links to other services:** To ensure that the service works as it was intended to work, it will be important to establish good working relationships with other agencies at an early stage. This includes not only the agencies that might refer people to the service (police, ambulance service, emergency department), but also agencies that might provide follow-up / brief interventions, and longer-term treatment and support.

- **Funding:** This should be through a multi-agency partnership, involving all relevant stakeholders, including the local authority, NHS, police and ambulance service.

- **Service delivery:** Will the service be provided by the statutory or voluntary sector?

- **Monitoring and evaluation:** This allows service planners and providers to ascertain whether the service is meeting the needs it was intended to meet, and to determine whether local needs are changing.
6.29 Funding emerged as a key issue in this research, particularly in relation to the funding of designated places. It may be that funding would be more readily available if the link to treatment was better structured. However, service providers may feel at risk if they cannot meet targets of referrals / access to treatment. Commissioners and planners should therefore discuss with service providers realistic aims and objectives for meeting the immediate care needs of clients and whether, and how, that can be combined with further intervention with those people who have chronic alcohol problems.

Recommendations

6.30 There should be a strategic and partnership approach at local level to planning and funding services to meet the care needs of drunk and incapable people.

6.31 The findings of this study suggest that in some local areas, there have been difficulties agreeing who should take responsibility for planning and delivering services for drunk and incapable people. In our view, the strategy for addressing the care needs of drunk and incapable people should be part of a wider local alcohol strategy, and Alcohol and Drug Partnerships are therefore best placed to take the lead on this.97

6.32 Local areas should undertake a local area needs assessment prior to planning services for drunk and incapable people. Locally-gathered intelligence may provide a more comprehensive and detailed picture than it has been possible to provide here.

6.33 The provision of services requires the involvement of a range of agencies but should include at the very least, health, social work, the police, the ambulance service and the voluntary sector. There are potential cost savings to be made in shifting the balance of care from high-resource-intensive emergency services to services that are specifically targeted at this population.

6.34 At the same time, the NHS, in particular, should take a much greater role in the establishment and running of services than they do at present in some areas. NHS input is needed not only to address people’s acute care needs when they are intoxicated, but also the longer-term care needs of alcohol-dependent people.

6.35 Local strategies for responding to the needs of drunk and incapable people should include interventions that help to prevent people from becoming drunk and incapable in the first place. Examples of the use of taxi marshals and the Street Pastor initiatives around Scotland are perceived to be beneficial and should be considered more widely.

97 As part of implementation of the recommendations of the Scottish Government's Delivery Reform Group, Alcohol and Drug Partnerships (ADPs) replaced Alcohol and Drug Action Teams from 1 October 2009. ADPs should be firmly embedded within wider arrangements for community planning. Governance and accountability arrangements should be consistent with existing accountability arrangements between Scottish Government and local partners, chiefly Single Outcome Agreements with Community Planning Partnerships and the NHS performance management arrangements, including HEAT.
6.36 Some people will have to be detained in custody because of the other offences they have committed. The care needs of these individuals should be assessed and met by a suitably trained individual.

6.37 At the same time, the use of technology, for example through cell monitoring systems, may provide an additional (not an alternative) support for monitoring intoxicated people in custody.

6.38 Protocols should be developed between the police, ambulance service, emergency department and any alternative services set up to manage the care needs of intoxicated people. These protocols should clearly specify the target group for the alternative services, how people are referred to them, how the services operate, and how they can make referrals to other agencies to address longer-term care needs.

6.39 Finally, services need to have an effective way of linking people to treatment and support. However, commissioners and planners should discuss with service providers realistic aims and objectives for meeting the immediate care needs of clients and whether, and how, that can be combined with further intervention with those people who have chronic alcohol problems.
REFERENCES


John T (2006) *An independent evaluation of the Mobile Medical Response Unit and Cardiff Medical Treatment Centre arrangement in Cardiff City Centre.*


APPENDIX A. EXPLANATORY NOTES ON SECONDARY DATA

Information Services Division data

A.1 The ISD data provides information on the numbers and characteristics of people who have been admitted to an acute general hospital (for at least one night) and then discharged who have a diagnosis of acute (alcohol) intoxication, over a one-year period (2006-07). The data does not directly address the question about the need for a system of designated places, as those who are admitted to hospital are likely to be at the more severe end of the intoxication spectrum and may well have other problems requiring medical attention. Many of these people may not, therefore, be suitable for a designated place. However, the data are likely to include some people who have to be admitted only for vital signs monitoring or to treat minor injuries — a level and type of care which potentially could be provided in a designated place.

A.2 There are some important issues to note about this ISD data.

- The first is that data on both the number of episodes (discharges) and the number of patients was provided by ISD. This was necessary because the same individual person might be admitted more than once with the same diagnosis, for example, if they are repeatedly binge-drinking.
- Secondly, data was provided on those with a primary diagnosis (main condition) of acute intoxication, in addition to those with a diagnosis of acute intoxication in any position (i.e. other conditions). Those with a primary diagnosis of acute intoxication are most likely to be those who are suitable for a designated place.
- Thirdly, caution is necessary when interpreting these figures. The recording of alcohol misuse may vary from hospital to hospital. Where alcohol misuse is suspected but unconfirmed it may not be recorded by the hospital.
- Finally, some data was provided by the local authority where the patient resided and other data by the hospital discharged from. It is useful to have both sets of data, particularly for those local authority areas which do not have an acute hospital and those which have more than one.

Police data

A.3 The data provided by police forces is based primarily on the number of charges (episodes) of people being drunk and incapable, rather than the number of people charged. However, some forces were also able to provide

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98 This was the latest available data at the time the report was drafted.
99 The main condition is the condition, diagnosed at the end of the episode of health care, primarily responsible for the patient’s need for treatment or investigation.
100 In addition to the main condition, the record may list separately other conditions or problems dealt with during the episode of health care. Other conditions are defined as those conditions that co-exist or develop during the episode of healthcare and affect the management of the patient.
the number of repeat offenders, i.e. the number of people who have been charged more than once in the same year, but this was not possible for all forces.

A.4 The data included both the local authority where the offence occurred and the local authority of residence of the person charged. It also included age, gender and ethnicity, whether the person was of no fixed abode, and the day and time of the offence.

A.5 However, not all forces could provide all the data requested, for example, in some areas data on ethnicity of the charged person, the time of the offence or the number of charges of people of no fixed abode, was not available.

A.6 It should be noted that charging practices vary between forces and that Lothian and Borders Police, in particular, do not routinely charge people with being drunk and incapable. Instead they take them home or place them in the care of a responsible person. Hence, the number of charges in Lothian and Borders is comparatively low. Notes on all forces’ charging policies are annotated to the relevant tables in the main body of the report.

Emergency department data from Quality Improvement Scotland (QIS)

A.7 Fifteen hospital emergency departments took part in the QIS audit during a randomly selected ten-day period in October and November 2005. It involved recording the number of patients who presented at emergency departments, where alcohol was considered to be a contributory factor.

A.8 Criteria for identification of whether an attendance was alcohol-related included patients reporting that they had consumed alcohol prior to their attendance, the smell of alcohol on their breath or signs of obvious intoxication. Admitted patients were tracked until discharge from hospital for a maximum of seven days.

A.9 QIS provided a breakdown of the data on those who presented with intoxication by age, gender, hospital, local authority of residence, by day and time of presentation, whether admitted and length of stay.

101 Note that the ten-day period may not necessarily be representative of emergency department use at other times of the year.
# APPENDIX B. TABLES

Table B.1: Emergency department (ED) data: estimated number of intoxicated presentations by NHS Board, based on data from 2005-06

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>Total number of ED presentations, 2005-06</th>
<th>Est. number of intoxicated presentations – 2.4% of total</th>
<th>Est. number of intoxicated presentations, not admitted – 1.6% of total</th>
<th>Est. number of intoxicated presentations, with no other presenting condition – 0.6% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>105,740</td>
<td>2,538</td>
<td>1,692</td>
<td>634</td>
</tr>
<tr>
<td>Borders</td>
<td>20,115</td>
<td>483</td>
<td>322</td>
<td>121</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>33,861</td>
<td>813</td>
<td>542</td>
<td>203</td>
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<tr>
<td>Fife</td>
<td>80,963</td>
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<td>486</td>
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<td>73,270</td>
<td>1,759</td>
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<td>1,351</td>
<td>507</td>
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<td>Greater Glasgow and Clyde</td>
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<td>9,476</td>
<td>6,318</td>
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<td>1,635</td>
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<td>Lanarkshire</td>
<td>173,295</td>
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<td>428</td>
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<td><strong>Scotland</strong></td>
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<td><strong>30,223</strong></td>
<td><strong>20,854</strong></td>
<td><strong>7,555</strong></td>
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</table>
Table B.2: General acute hospital inpatient discharges with a diagnosis of acute intoxication (in any position) and total discharges, by Local Authority of residence, 2006-07

<table>
<thead>
<tr>
<th>Local authority of residence</th>
<th>All discharges</th>
<th>Number of acute Intoxication discharges</th>
<th>Number of acute intoxication discharges per 10,000 all discharges</th>
<th>Number of patients with primary diagnosis of acute intoxication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>Male</td>
<td>Female</td>
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<tr>
<td>Aberdeen City</td>
<td>37,884</td>
<td>324</td>
<td>244</td>
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<td>Aberdeenshire</td>
<td>37,502</td>
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<td>Angus</td>
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<tr>
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<td>Clackmannanshire</td>
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<td>Dumfries &amp; Galloway</td>
<td>32,304</td>
<td>143</td>
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<td>51</td>
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<td>Dundee City</td>
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<td>East Lothian</td>
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<td>Inverclyde</td>
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<td>Midlothian</td>
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<td>Moray</td>
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<td>North Ayrshire</td>
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<td>Perth &amp; Kinross</td>
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<td>West Lothian</td>
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<td>195</td>
<td>78</td>
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</table>

Scotland: 1,097,986 7,785 5,865 1,920 75 25 70.90 1,440
Table B.3: General acute hospital inpatient discharges with a diagnosis of acute intoxication (in any position) and total discharges, by NHS Board area of residence, 2006-07

<table>
<thead>
<tr>
<th>NHS Board area of residence</th>
<th>All discharges</th>
<th>Acute Intoxication discharges</th>
<th>Number of acute intoxication discharges per 10,000 all discharges</th>
<th>Number of patients with primary diagnosis of acute intoxication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>92,116</td>
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<td>Borders</td>
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<td>98.24</td>
<td>64</td>
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<tr>
<td>Dumfries &amp; Galloway</td>
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<td>526</td>
<td>68.68</td>
<td>123</td>
</tr>
<tr>
<td>Western Isles</td>
<td>7,601</td>
<td>26</td>
<td>34.21</td>
<td>13</td>
</tr>
</tbody>
</table>

**Scotland**                          | **1,097,986**  | **7,785**                     | **70.90**           | **1,920**       | **75** | **25**   | **1,097,986**                                  | **1,440**                                     |
Table B.4: Charges for being drunk and incapable under section 50(1) of the Civic Government (Scotland) Act 1982, by police force and local authority, April 2007 – March 2008

<table>
<thead>
<tr>
<th>Police force / local authority where offence was committed</th>
<th>Number of drunk and incapable charges</th>
<th>No. (%) D&amp;I charges</th>
<th>Average (mean) age of D&amp;I charges (range)</th>
<th>% D&amp;I charges no fixed abode*</th>
<th>No. (%) D&amp;I charges resident in same local authority area</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Central</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clackmannanshire**</td>
<td>16</td>
<td>15 (94%)</td>
<td>39.9 (14 to 59)</td>
<td>3 (19%)</td>
<td>13 (81%)</td>
</tr>
<tr>
<td>Falkirk</td>
<td>82</td>
<td>60 (73%)</td>
<td>38.1 (14 to 77)</td>
<td>1 (1%)</td>
<td>71 (80%)</td>
</tr>
<tr>
<td>Stirling</td>
<td>63</td>
<td>47 (75%)</td>
<td>38.6 (15 to 64)</td>
<td>5 (8%)</td>
<td>38 (60%)</td>
</tr>
<tr>
<td><strong>Dumfries &amp; Galloway</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>129</td>
<td>114 (88%)</td>
<td>40.4 (13 to 71)</td>
<td>15 (12%)</td>
<td>107 (83%)</td>
</tr>
<tr>
<td><strong>Fife</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fife</td>
<td>369</td>
<td>293 (79%)</td>
<td>34.6 (13 to 82)</td>
<td>7 (2%)</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Grampian</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aberdeen City</td>
<td>83</td>
<td>62 (75%)</td>
<td>37.1 (14 to 68)</td>
<td>3 (4%)</td>
<td>68 (82%)</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>40</td>
<td>33 (83%)</td>
<td>35.3 (14 to 68)</td>
<td>4 (10%)</td>
<td>32 (80%)</td>
</tr>
<tr>
<td>Moray</td>
<td>76</td>
<td>69 (91%)</td>
<td>39.7 (15 to 71)</td>
<td>6 (8%)</td>
<td>71 (93%)</td>
</tr>
<tr>
<td><strong>Lothian &amp; Borders</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Borders**</td>
<td>8</td>
<td>6 (75%)</td>
<td>36.5 (18 to 61)</td>
<td>0</td>
<td>8 (100%)</td>
</tr>
<tr>
<td>East Lothian**</td>
<td>6</td>
<td>6 (100%)</td>
<td>43.7 (18 to 76)</td>
<td>1 (17%)</td>
<td>4 (67%)</td>
</tr>
<tr>
<td>Edinburgh City</td>
<td>75</td>
<td>60 (80%)</td>
<td>40.1 (16 to 75)</td>
<td>12 (16%)</td>
<td>54 (72%)</td>
</tr>
<tr>
<td>Midlothian**</td>
<td>6</td>
<td>6 (100%)</td>
<td>38.5 (19 to 58)</td>
<td>1 (17%)</td>
<td>5 (83%)</td>
</tr>
<tr>
<td>West Lothian**</td>
<td>8</td>
<td>7 (88%)</td>
<td>39.1 (26 to 53)</td>
<td>1 (12%)</td>
<td>7 (88%)</td>
</tr>
<tr>
<td><strong>Northern</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highland</td>
<td>616</td>
<td>509 (83%)</td>
<td>37.1 (13 to 84)</td>
<td>5 (1%)</td>
<td>515 (84%)</td>
</tr>
<tr>
<td>Orkney**</td>
<td>8</td>
<td>6 (75%)</td>
<td>39.0 (19 to 58)</td>
<td>1 (13%)</td>
<td>6 (75%)</td>
</tr>
<tr>
<td>Shetland</td>
<td>44</td>
<td>39 (89%)</td>
<td>41.8 (19 to 72)</td>
<td>0</td>
<td>38 (86%)</td>
</tr>
<tr>
<td>Western Isles</td>
<td>82</td>
<td>70 (85%)</td>
<td>37.5 (16 to 68)</td>
<td>2 (2.4%)</td>
<td>74 (90%)</td>
</tr>
<tr>
<td><strong>Strathclyde</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Argyll and Bute</td>
<td>139</td>
<td>112 (81%)</td>
<td>41.4 (15 to 86)</td>
<td>19 (14%)</td>
<td>103 (74%)</td>
</tr>
<tr>
<td>East Ayrshire</td>
<td>73</td>
<td>61 (84%)</td>
<td>41.8 (15 to 77)</td>
<td>3 (4%)</td>
<td>57 (78%)</td>
</tr>
<tr>
<td>East Dunbartonshire</td>
<td>56</td>
<td>52 (93%)</td>
<td>35.8 (14 to 72)</td>
<td>1 (2%)</td>
<td>40 (71%)</td>
</tr>
<tr>
<td>East Renfrewshire**</td>
<td>22</td>
<td>20 (91%)</td>
<td>36.6 (17 to 74)</td>
<td>0</td>
<td>8 (36%)</td>
</tr>
<tr>
<td>Glasgow City</td>
<td>1,413</td>
<td>1,142 (81%)</td>
<td>42.0 (12 to 86)</td>
<td>26 (2%)</td>
<td>1,091 (77%)</td>
</tr>
<tr>
<td>Inverclyde</td>
<td>182</td>
<td>161 (88%)</td>
<td>42.1 (13 to 76)</td>
<td>3 (2%)</td>
<td>157 (86%)</td>
</tr>
<tr>
<td>North Ayrshire</td>
<td>166</td>
<td>138 (83%)</td>
<td>40.7 (14 to 74)</td>
<td>5 (3%)</td>
<td>124 (75%)</td>
</tr>
<tr>
<td>North Lanarkshire</td>
<td>433</td>
<td>371 (86%)</td>
<td>40.0 (13 to 90)</td>
<td>31 (7%)</td>
<td>350 (81%)</td>
</tr>
<tr>
<td>Renfrewshire</td>
<td>215</td>
<td>177 (82%)</td>
<td>42.2 (15 to 80)</td>
<td>5 (2%)</td>
<td>164 (76%)</td>
</tr>
<tr>
<td>South Ayrshire</td>
<td>65</td>
<td>47 (72%)</td>
<td>46.9 (17 to 70)</td>
<td>2 (3%)</td>
<td>38 (58%)</td>
</tr>
<tr>
<td>South Lanarkshire</td>
<td>323</td>
<td>286 (89%)</td>
<td>38.4 (13 to 73)</td>
<td>15 (5%)</td>
<td>242 (75%)</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>247</td>
<td>208 (84%)</td>
<td>40.8 (14 to 77)</td>
<td>5 (2%)</td>
<td>187 (76%)</td>
</tr>
<tr>
<td><strong>Tayside</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angus**</td>
<td>28</td>
<td>24 (86%)</td>
<td>39.1 (16 to 66)</td>
<td>2 (7%)</td>
<td>23 (82%)</td>
</tr>
<tr>
<td>Dundee City</td>
<td>307</td>
<td>272 (89%)</td>
<td>39.5 (12 to 80)</td>
<td>10 (3%)</td>
<td>269 (88%)</td>
</tr>
<tr>
<td>Perth &amp; Kinross**</td>
<td>13</td>
<td>10 (77%)</td>
<td>33.9 (17 to 60)</td>
<td>1 (8%)</td>
<td>8 (62%)</td>
</tr>
<tr>
<td><strong>British Transport Police</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scotland</td>
<td>5,502</td>
<td>4,559 (83%)</td>
<td>40.0 (12 to 77)</td>
<td>2 (2%)</td>
<td>95 (86%)</td>
</tr>
</tbody>
</table>

* Includes hostel residents; ** Note small numbers in these areas
NA = not available.
Table B.5: Drunk and incapable charges by police force and local authority, number of repeat offenders and their number and % of charges, 2007-08

<table>
<thead>
<tr>
<th>Police force* (Total no. D&amp;I charges)</th>
<th>Local authority where offence committed</th>
<th>No. of repeat offenders</th>
<th>Number of drunk and incapable charges</th>
<th>No of charges by repeat offenders</th>
<th>% of charges by repeat offenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>Clackmannanshire**</td>
<td>1</td>
<td>16</td>
<td>4</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>Falkirk</td>
<td>5</td>
<td>82</td>
<td>21</td>
<td>26%</td>
</tr>
<tr>
<td></td>
<td>Stirling</td>
<td>6</td>
<td>63</td>
<td>17</td>
<td>27%</td>
</tr>
<tr>
<td>Fife</td>
<td>Fife</td>
<td>33</td>
<td>369</td>
<td>108</td>
<td>29%</td>
</tr>
<tr>
<td>Grampian</td>
<td>Aberdeen City</td>
<td>6</td>
<td>83</td>
<td>25</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>Aberdeenshire</td>
<td>2</td>
<td>40</td>
<td>6</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>Moray</td>
<td>9</td>
<td>76</td>
<td>38</td>
<td>50%</td>
</tr>
<tr>
<td>Lothian &amp; Borders</td>
<td>Scottish Borders**</td>
<td>0</td>
<td>8</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>East Lothian**</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Edinburgh</td>
<td>3</td>
<td>75</td>
<td>7</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>Midlothian**</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>West Lothian**</td>
<td>0</td>
<td>8</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Strathclyde</td>
<td>Argyll &amp; Bute</td>
<td>12</td>
<td>139</td>
<td>38</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td>East Ayrshire</td>
<td>4</td>
<td>73</td>
<td>8</td>
<td>11%</td>
</tr>
<tr>
<td></td>
<td>East Dunbartonshire</td>
<td>3</td>
<td>56</td>
<td>6</td>
<td>11%</td>
</tr>
<tr>
<td></td>
<td>East Renfrewshire**</td>
<td>0</td>
<td>22</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Glasgow</td>
<td>127</td>
<td>1,413</td>
<td>389</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>Inverclyde</td>
<td>22</td>
<td>182</td>
<td>76</td>
<td>42%</td>
</tr>
<tr>
<td></td>
<td>North Ayrshire</td>
<td>16</td>
<td>166</td>
<td>46</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>North Lanarkshire</td>
<td>51</td>
<td>433</td>
<td>145</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td>Renfrewshire</td>
<td>17</td>
<td>215</td>
<td>63</td>
<td>29%</td>
</tr>
<tr>
<td></td>
<td>South Ayrshire</td>
<td>5</td>
<td>65</td>
<td>11</td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td>South Lanarkshire</td>
<td>34</td>
<td>323</td>
<td>106</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td>West Dunbartonshire</td>
<td>23</td>
<td>247</td>
<td>66</td>
<td>27%</td>
</tr>
<tr>
<td>Tayside</td>
<td>Angus**</td>
<td>3</td>
<td>28</td>
<td>10</td>
<td>36%</td>
</tr>
<tr>
<td></td>
<td>Dundee</td>
<td>37</td>
<td>307</td>
<td>130</td>
<td>42%</td>
</tr>
<tr>
<td></td>
<td>Perth &amp; Kinross**</td>
<td>0</td>
<td>13</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>British Transport Police</td>
<td>Scotland</td>
<td>5</td>
<td>109</td>
<td>12</td>
<td>11%</td>
</tr>
</tbody>
</table>

* Dumfries and Galloway Police and Northern Constabulary were unable to provide data on repeat offenders.
**Note small numbers in these areas
APPENDIX C. ADDITIONAL DETAIL ON ADMISSION AND EXIT
PROCEDURES AND STAFFING AT BEECHWOOD
HOUSE AND ALBYN HOUSE

Beechwood House

Admission / referral criteria

C.1 The designated place is open to anyone who is drunk and incapable but in
practice there are some restrictions. There is an exclusion list of people who
have behaved violently to staff or other residents in the past, or who refuse to
abide by the rules, e.g., surrendering medication. There is a permanent and a
three-month exclusion list.

C.2 The exclusion criteria are:

• Inability to walk (so would require significant handling by staff)
• Being dependent on insulin
• Violent or threatening behaviour
• Severe mental health issues
• Acute learning disability
• Un-cooperative on admission

C.3 It is not a requirement that all persons going to Beechwood are medically
screened, nor that an assessment is done in an emergency department. If a
person has a breath alcohol level (or blood alcohol equivalent) of more than
400mg\textsuperscript{102} per 100ml of blood or evidence of trauma, especially head injury,
staff request a medical assessment prior to admission. People who are
insulin-dependent are not accepted because individuals cannot administer
insulin when intoxicated and sugar levels are affected by alcohol.

C.4 Self-referrals are not accepted.

C.5 The police have to decide whether the person is suitable for the designated
place. For example, they should not take someone to Beechwood who is
behaving violently. If someone is injured, they would take them to the
emergency department or a GP, who might then refer the person back to
Beechwood. The police also confirm that the person is not facing criminal
charges and check to see whether there is a history of violence or sex
offences. In these cases, they would be taken to the cells. Police obtain the
name of the person (if possible) and phone Beechwood to advise that they
propose to bring him/her in. If the person is not on the exclusion list, police
will then take him / her to the designated place.

C.6 In some cases, a GP or community psychiatric nurse will have identified the
person as drunk and incapable and arrange to take them to Beechwood.

\textsuperscript{102} In the UK, the legal limit for drivers is 80 mg of alcohol per 100 ml of blood.
Where medication is required to assist their recovery, the GP will provide a prescription to be administered by Beechwood staff. If it is a police referral, staff may ask a GP or NHS24 for a prescription.

C.7 If a person presents to the emergency department as drunk and incapable but with no injury or other reason to remain in the emergency department, he / she will be sent to Beechwood. If a person shows signs of being depressed, mentally ill or at risk of suicide, the emergency department refers them to the hospital-based mental health liaison nurses. The liaison nurse will make an assessment including doing a blood alcohol level test. If the nurse is concerned about sending that person home, he / she will be asked if they are willing to go to Beechwood as a safe place to stay for the night. The mental health nurse team then undertakes to see that person the next morning. Where the referral has been straight from the emergency department to Beechwood, the mental health nurses are still given details and will offer to see the person the next day.

C.8 In all cases, the police or NHS escort the person to Beechwood.

Admission procedures

C.9 The staff ask for the person’s details (name, address, etc.) and get the signature of the escort. Clients are asked to empty their pockets, take off their shoes and hand in any medication. Staff do not formally search the person but they do check pockets. Possessions are logged and stored.

C.10 Any injuries or history of mental health problems are checked prior to admission and a risk assessment carried out. If drugs are present, the person may be admitted, but it will depend on the type and level of drug misuse.

C.11 Staff explain to the clients why they are in the designated place and that the police will be contacted if they attempt to leave before their blood alcohol level falls to below 100mg.

Leaving the designated place

C.12 Staff will attempt to engage with clients and ask whether they would like further support for their alcohol issues or access to other services such as substance misuse services, housing, bereavement or debt counselling. Many simply leave, but some take up the offer of a stay in a support bed and / or move on to the rehabilitation service. Eighty-seven referrals moved into a support bed in the period March 2007 to April 2008.

Staffing

C.13 A multi-disciplinary team of twelve with backgrounds in social work, nursing and social care works across both facilities in Beechwood. There is one trained nurse who provides clinical assessment and can identify other

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103 The number of referrals does not equate to the number of clients as there are repeat attenders
problems. There are three shifts in the designated place over 24 hours and a minimum of two staff on duty for each shift, one of whom is a senior staff member. Additional staff can be called in from the residential service, if required.

C.14 Crossreach provides training for all staff including first aid training and health and safety. Staff are also trained in motivational interviewing to help them engage with clients the morning after, and some have received training in substance misuse from Osprey House and STRADA.

Albyn House

Admissions / referral criteria

C.15 Police carry out relevant criminal record checks prior to admission. They will also remove any drugs paraphernalia. Police will phone ahead with details about the person and then escort the client to Albyn House. The police officer will provide an admission statement which indicates what they know about the client: name, address, date of birth and what time and date the person was detained. These details are checked against the designated place database to establish if the client has been admitted before. If the person has no ID or is comatose when picked up, the staff will go out and see him / her. If the person is a regular client, they can identify him / her but do not take someone who has no ID or who cannot be identified.

C.16 The criteria for admission are that a person is:

- 18 years of age or over (or 16 plus if guardian consent is given)
- Referred from the police, Albyn House (residential), social services, Cyrenians or the homelessness unit
- Incapable of protecting himself or herself from physical harm
- Intoxicated with alcohol
- Willing to enter the designated place
- Conscious
- Not displaying violent behaviour.

C.17 If someone has assaulted a member of staff and there is an outstanding court case, s/he will not be allowed in. But once the case is over the individual can be admitted. No one gets barred permanently. There are very few assaults of staff.

C.18 If the person is 16/17 years old, the police will usually take them home. Such incidents are often associated with pop concerts.

C.19 The client is assessed for eligibility, drug and alcohol use, injuries or medical conditions and current condition. A client risk assessment form is completed. If staff have any concerns about drug misuse, clients are sent to the emergency department, although it is estimated that this applies to only about 1-1.5% of clients.
C.20 The client is assessed and breathalysed using a Lion Alco-meter breathalyser. If the blood alcohol equivalent is very low, staff exercise discretion on whether to accept the referral. If the reading is above 400mg\textsuperscript{104} per 100ml of blood the client is taken to the emergency department by the referring agency. Otherwise if the reading is below 400mg and the client is not troublesome they can then be admitted into the designated place. If clients are unfit to provide a breath specimen, they are taken to the emergency department.

C.21 Clients are searched (pat search) by staff and their belongings recorded, stored securely and then returned on departure.

C.22 Throughout the process of admission, staff members aim to communicate with the client in a manner which is easily understood and enables informed consent.

C.23 Admission is voluntary. Clients are free to leave at any time. However, if they are assessed to be at risk when they leave, staff are required to notify police.

C.24 On occasion when all four beds are in use, clients would be taken to the local police.

C.25 The designated place has a detailed policies and procedures manual governing the care of clients. The emphasis is on the need for safety, treating clients with respect and promoting their dignity and their human rights.

\textit{Leaving the designated place}

C.26 When the client is sober enough to be discharged, they will be offered a shower. The staff try to take the opportunity before clients leave to engage with them about their other needs. They explore how to assist them with information or referral to other services. First-time clients are often embarrassed and want to leave as quickly as possible but some clients will discuss with staff how they came to be at the designated place.

C.27 The client may be breathalysed again to determine their residual level of intoxication. Staff also send a follow-up letter with health information and details of local support organisations plus a card for the Albyn House support worker.

C.28 Staff return the client’s clothes and property, and records are updated. Staff will inform police if a client discharges themselves against their advice.

C.29 Clients are expected to arrange and pay for their own transport home.

\textsuperscript{104}In the UK, the legal limit for drivers is 80 mg of alcohol per 100 ml of blood.
**Staffing**

C.30 Staff are employed for aptitude. While at the designated place they will be trained to SVQ level 3, and managers to HND or SVQ level 4. Training includes key working skills, anti-discrimination practice, child protection, risk assessment, drugs and alcohol awareness, mental health awareness, and personal safety and awareness. A number of staff have a social work / health background but this is not a prerequisite.

C.31 Albyn House has a Home Office licence to administer diazepam. Staff can phone NHS24 or a GP to get a prescription.

C.32 The total staff complement across the designated place and the hostel is sixteen: three managers, one support worker who is a social worker, ten social care workers, a cook and a part-time administrator.

C.33 There are three shifts in the designated place. There are always two staff on duty. In addition, a manager is on call for the night shift and on duty during both day shifts.